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CONTENTS AND SUBJECT INDEX

Management of a Surgical Service. Eugene H. Pool, M.D., New York..1

Roentgenograms of the Fetal Skeleton as a Positive Sign of Pregnancy. Irving F. Stein, M.D., and Robert A. Arens, M.D., Chicago.....4

Inflammation of the Deep Calcaneal Bursa. Arthur E. Hertzler, M.D., Halstead, Kan.....8

Hereditary Cleidocranial Dysostosis. I. J. McCurdy, M.D., and R. W. Baer, M.D., Frederick, Md.....9

A Form of Polypoid Colitis as a Late Stage of Amebic Dysentery: Report of Case. Laurence E. Hines, M.D., Chicago.....12

Resin Dermatitis: Report of Case. L. G. Beinhauer, M.D., Pittsburgh.....13

The Therapeutic Value of Egg Yolk in Rickets. Alfred F. Hess, M.D., New York.....15

The Treatment of Vomiting. Bernard Fantus, M.D., Chicago.....17

The Treatment of Congenital Dacryocystitis. Lewis W. Crigler, M.D., New York.....23

CLINICAL NOTES, SUGGESTIONS AND NEW INSTRUMENTS

Ribs Fractured by Cough. Gerald B. Webb, M.D., and G. Burton Gilbert, M.D., Colorado Springs, Colo.....25

Support for Hernia, Relaxed Sacro-Iliac Ligaments and Visceral Proptosis. Edward J. Brown, M.D., Minneapolis 25

A Gastro-Intestinal Holder for Visceral Anastomosis. Chauncey E. Tennant, M.D., Denver.....26

A New Apparatus for the Administration of Fluids. Edward F. Lane, New Brunswick, N. J.....26

Removal of Adhesive Bandage. Harper F. Zoller, Detroit.....27

EDITORIALS

San Francisco Session.....43

Treatment of Hypertension by Salt Restriction.....44

Dementia Praecox and Endocrine Disorder.....44

CURRENT COMMENT

The President-Elect.....45

Subcutaneous Fibroid Nodules in Rheumatism.....46

A Test for Typhoid Infection.....46

Toxicity of Carbon Tetrachlorid.....47

(Subject Index on next page)

PROCEEDINGS OF THE SAN FRANCISCO SESSION

Minutes of the House of Delegates (Continued).....28

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See Page 3

SUBJECT INDEX TO THIS ISSUE

The letters used to explain in which department the matter indexed appears are as follows: The Star (*) indicates an Original Article; "E," Editorial; "C," Correspondence; "T," Therapeutics; "Ml," Medicolegal; "P," Propaganda for Reform; "ME," Medical Economics.

A. M. A. address of President..... 30
minutes of 74th Annual Session of..... 28
proposed amendment 42
remarks of President-elect..... 33
report of Board of Trustees..... 39
reports of officers.....34, 36, 37, 38
resolutions 35, 40, 41, 42
San Francisco Session.....E-43
Adhesive bandage, removal of.....*27
Anemia, behavior of heated serum in..... 81
pathogenesis of 81
Aneurysm of brachiocephalic trunk..... 77
Angiomas, muscular 78
Ankylosis ab-68
Anus, resection of rectum with restoration of 71
Aorta, rupture of..... 75
Aphasia 80
Apparatus for administration of fluids.....*26
Arthritis, gonorrheal 77
Asthma, alimentary 82
Bacillus, Flexner's 60
Bilharziasis, treatment of.....C-60
Bladder, prolapse, hydro-ureter and hydronephrosis after ab-66
Blood, bleeding and coagulation time in new-born 72
carbon dioxid absorption curve of..... 70
circulation and stair running..... 70
clot, gage for retraction of..... 79
glycolysis, with stomach cancer..... 77
hemoglobin, instrument for determination of 70
myeloid reaction with loss of granulocytes from 81
picture during radiotherapy..... 79
platelet, genesis of..... 74
platelets and function of vessels..... 81
pressure after delivery.....ab-67
pressure, high 81
pressure, high, treatment by salt restriction E-44
pressure, low 81
vessels, autoplastic reduction of lumen of 80
Bone growth and castration..... 74
Book Notices..... 63
Books Received .....**Adv. page 26**
Brain hemorrhage in eclampsia..... 78
Breast cancer ab-69
Bursa, calcaneal, inflammation of..... *8
Calcaneum, inflammation of calcaneal bursa. *8
Calcium, deficient diet, effect of..... 74
Cancer, behavior of heated serum in..... 81
evolution of, and pathologic physiology of the carcinomatous 77
radiotherapy of ab-69
Carbohydrate metabolism, and Vitamin B... 70
Carbon dioxid absorption curve of blood... 70
tetrachlorid toxicity of.....E-47
Castration and bone growth..... 74
Cerebellar function, research on..... 80
Cholera 77
stools in 72
Chromosomal and incretory hormones..... 82
Colitis, polypoid and amebic dysentery.....*12
Constipation, rectopelvic 77
Correspondence 59
Cough, ribs fractured by.....*25
Cyanosis, cause of..... 74
Cyst of jaw, adamantine..... 79
Cystocele and high rectocele.....ab-65
Dacryocystitis, congenital *23
Deaths 58
Dementia praecox 73
praecox and endocrine disorder.....E-44
Dermatitis, resin *13
venenata C-59
Diabetes, insulin in.....70, 71
phlorizin diabetes..... 71
Diagnosis, uniform classification in degrees. 81
Diazo reaction, Ehrlich's..... 82
Diet, effect of calcium deficient diet..... 74
necropsy findings in a vegetarian..... 80
Diphtheria wound 81
bacilli, virulence test of..... 60
Diuresis, mercury 82
Duodenum obstruction ab-68
Dysentery, amebic and polypoid colitis.....*12
Dysostosis cleidocranial, hereditary..... *9
Ecchymosis with salpingitis.....ab-67
Eclampsia, hemorrhage in nerve centers in.. 78
Edema, treatment of..... 79
Egg yolk in rickets.....*15
Elephantiasis 78
Embolectomy 78
Embryomas of tubes..... 78
Encephalitis, etiology of..... 80
sequelae 76, 77
Endocarditis lenta 76
with gangrene of legs..... 76
Endometrium and ovarian function.....ab-66
Epinephrin action 81
Exercise, effects of stair running..... 70
Face, reconstruction of..... 78
Fallopian tubes, embryomas of..... 78
patency test of.....ab-65
permeability test of..... 82
Fees, employer's liability for.....Ml-64
Femur, fracture of neck of.....71, 78
Fetus, roentgenograms of, sign of pregnancy.*4
Fingers, hippocratic 77
Fluids, administration of.....*26
Forearm, paramycetoma of..... 74
Foreign Letters..... 52
Galvanism, after-action of..... 82
Gastro-intestinal holder for visceral anastomosis *26
Glycosuria, renal, new type of..... 76
Goiter, venous pulse and apex tracings in.. 78
Gonorrheal arthritis 77
Gynecology, teaching of.....ab-66
Heart action 81
diastolic aortic murmurs..... 81
quinidin in auricular fibrillation..... 76
rupture of 75
Height and social classes..... 55
Hemosexuality and sadism..... 80
Hernia of uterus..... 80
support for *25
Hospitals, management of surgical service.. *1
Hydronephrosis and hydro-ureter.....ab-66
congenital 79
Hydrostatic test 80
Hydro-ureter and hydronephrosis.....ab-66
Hysterotomy under local anesthesia.....ab-67
Immunity and skin..... 81
metal salts, to produce immune serums... 77
Infant, postmortem findings in new-born... 72
Infectious diseases mortality in France.... 54
Insanity, heredity of..... 80
Insulin in diabetes.....70, 71
treatment, fund for..... 50
Insurance examinations and nutrition..... 56
Intellectual processes 80
Internal secretions; chromosomal and incretory hormones 82
Intestines, stasis 77
stasis, etiology of..... 77
Jaw, adamantine cyst of..... 79
Joints, syphilis of..... 81
Knee, internal derangements of..... 74
Labor, blood pressure after.....ab-67
Lactation and placenta.....ab-66
Leg, gangrene of, with endocarditis..... 76
Leprosy 73
complement fixation in..... 72
dietotherapy of 72
rat leprosy in man..... 77
Leukorrhea, chronic ab-65
Liability for fees.....Ml-64
Lipodystrophia progressiva 73
Liquor merchants, sensibilities of..... 53
Liver abscess 74
Malaria rebellious to quinin..... 79
Manganese chlorid in production of immune serums 77
Marriages 57
Medical Education, Registration..... 61
Medicine, military, medals awarded in.... 51
Medicolegal 64
Meningism, toxic 78
Meningitis, septic 73
cerebrospinal, in Formosa..... 51
Mental hygiene, French league..... 52
Mercury diuresis 82
Mesentery, sarcoma of..... 75
Microbiology 76
Military medicine, congress of..... 55
Murmurs, diastolic aortic..... 81
Myeloid reaction with loss of granulocytes from blood 81
National Board of Medical Examiners, report 61
Necropsies in new-born..... 72
Nervous system, vegetative periodicity in. 79
New and Nonofficial Remedies..... 27
News 47
Nipple, pigment in areola..... 60
Nutrition and insurance examinations..... 56
Obstetrics, modern ab-65
Ovaries, protection of, in irradiation..... 82
function of, and endometrium.....ab-66
Pain, uniform classification in degrees..... 81
Panel service, crisis in..... 52
Paramycetoma of forearm..... 74
Parathyroid and calcium deficient diet..... 74
Personality, the subconscious..... 57
Physicians, proposed order of..... 53
Placenta and lactation.....ab-66
accreta ab-64
placental infarcts ab-67
Plague, diagnosis of..... 73
in Porto Rico 73
in rats at Porto Rico..... 73
sputum, examination of..... 73
Pregnancy, intraperitoneal 75
pyelitis in ab-64, 73
roentgenograms of fetal skeleton as positive sign of..... *4
ruptured tubal 78
Privileged communications, physician notifying parents of daughter's infection Ml-64
Procain, dissociation of bulbar centers by. 79
Prohibition, industrial bootlegging..... 50
Prostate carcinoma ab-69
Pseudarthrosis, congenital 78
Psychology, intellectual processes..... 80
Pusey, Dr., President-elect.....E-45
Pyelitis in pregnancy.....ab-64, 73
Pylorospasm 81
Pyosalpinx perforating into rectum..... 78
Queries and Minor Notes..... 60
Quinidin in auricular fibrillation..... 76
Quinin wanted for Asia Minor..... 51
Rachitis, egg yolk in.....*15
Radium in Madagascar..... 51
Radius fractures 82
Rectocele and cystocele.....ab-65
Rectum, resection of, with restoration of anus 71
prolapse of 82
Resin dermatitis *13
Rheumatism, fibroid nodules in.....E-46
Rhus toxicodendron C-59
Ribs fractured by cough.....*25
Sacro-iliac joint, support for.....*25
St. Bartholomew's Hospital, octocentenary of 53
Salpingitis with ecchymosis ab-67
Sarcoma of mesentery 75
Scapula, fracture of..... 71
Scarlet fever, Wassermann in..... 74
Secretions, internal, and dementia praecox E-44
Sex perversions 80
ratio of sexes..... 55
Sigmoid, diverticulitis of..... 75
Skin and immunity 81
Society Proceedings..... 64
Spinal cord, tumor..... 71
Splanchnoptosis, support for.....*25
Sprue in tropics..... 73
State Board Examinations..... 62
Stomach, cancer, autolytic products in diagnosis of 77
cancer, glycolysis in blood with..... 77
ulcer ab-67, 82
ulcer, irradiation in..... 81
ulcer, pain phenomena in, duodenal and.. 81
ulcer, string test for.....ab-67
ulcers of duodenum and..... 80
ulcers, pharmacologic treatment..... 80
Suprarenal capsules, insufficiency of..... 79
senility and hypertrophy of..... 79
Surgery, management of surgical service.. *1
congenital diagnosis of..... 79
military, medals awarded in..... 51
plastic, of face 78
Syphilis in infants..... 79
superinfection in 81
Thrombosis of mesenteric artery..... 75
Tongue carcinoma 75
Tonics and Sedatives.....**Adv. page 22**
Tuberculosis, blood picture during radiotherapy of 79
bacilli, staining of..... 60
Typhoid, test for E-46
Typhus, fungus isolated from guinea-pigs inoculated with 74
Urea excretion, variability of..... 70
Uric acid excretion, effect of lactic and pyruvic acids on..... 70
Urine, leukocyte content of..... 82
Uterus cancer 82
cancer ab-65
hernia of 80
prolapse, hydro-ureter and hydronephrosis after ab-66
Vegetarian, necropsy findings in..... 80
Vitamin B and carbohydrate metabolism... 70
Vomiting, treatment of.....*17
Wassermann in scarlet fever..... 74
Weight and social classes..... 55
Workmen's compensation bill..... 53
Wrist, traumatism of..... 79

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MANAGEMENT OF A SURGICAL SERVICE*

EUGENE H. POOL, M.D.
NEW YORK

Not many years ago, the small surgical staffs, simple diagnostic and therapeutic measures and slow turnover required little management. Case records were largely a matter of memory, or consisted in brief notes. Under present conditions, however, with more active services, larger staffs, and more elaborate and complicated methods, systematization of the work has become essential, in order that time and energy may be conserved, thorough study of cases insured, and complete records made and filed. No service can be excused from making effective efforts toward these ends. The details, however, have not been standardized; therefore, individual experiences are of value, since they further a more general agreement on the proper methods to be employed.

Some years ago, we presented our ideas as to the systematization of a surgical service, and attempted to put the theories into execution.[1] Those initial efforts have been persisted in for about eight years. Although the ideals of those early days have become somewhat subdued and the enthusiasm less aggressive, the original plan has been followed with few changes. Our experience indicates that the principles originally advocated by Codman can be followed to advantage.

I will confine my remarks to general problems, and will avoid lengthy discussion of details of local interest, such as full time, the resident surgeon, duties of the house staff and the record system. Full time is still in the experimental stage; many of its former advocates are now its apologists; and in practice, much full time actually proves to be part time with explanations. When fully carried out, the expense is out of proportion to the results; stimulating contacts with the outside are not developed, and a man is legislated into research instead of pursuing it of his own volition.

Resident surgeons are necessities in the large and highly organized clinics and in certain teaching institutions, but elsewhere they function as luxuries for the senior attending surgeons and obstacles for the junior attending surgeons and the house staff. Now, training of the house staff is one of the most important duties and privileges pertaining to a service. It is a question whether, in the aggregate, more productive and effective training is not accomplished through the shifting house staff than through a resident staff. It is really a balance between a few men highly trained and many men well started. Obviously, however, both methods meet essential needs of the community.

At the outset, it must be emphasized that our Eastern ward services, and it is to them I refer particularly, differ from those which prevail in some parts of the country, in that the professional services are entirely gratuitious, no fees being allowed. This has evils, as well as advantages, but the custom is prevalent and promises to persist. The absence of pay cases facilitates a uniform system. This hospital rule has been extended to advantage in some services so that a patient referred by one of the staff ceases to be the exclusive property of that member. Such cases are not allowed to disrupt or interfere with the routine; they are handled according to the system outlined for all ward cases. Under these conditions, every case is a service case, never an individual's case.

Whether, however, an institution or service harbors free patients or pay patients, or both, the general principles pertaining to the handling of those patients does not differ in kind. Yet, the features on which I shall dwell can be applied only to a limited extent, if at all, in the private patient pavilion with innumerable independent privileged surgeons under little or no authority or control.

The average hospital has one or more ward surgical services, which are usually independent of one another, but occasionally, especially in teaching institutions, a surgical director presides over all surgical activities, the individual services then being independent units closely harmonized. This appears to be the ideal arrangement.

I will take a surgical division or service as the unit for discussion, assuming that there is no general director. The primary essentials are a continuous service and a graded staff. As no two men in a division are on the same plane, questions of prerogative and authority are largely avoided. The juniors rise in the absence of a superior; and in the absence of the senior, his associate acts for him, not independently. The policies decided on for the division are thus carried out continuously, and the acting senior does not attempt impetuously to blaze a new trail, a policy that seems at the moment to redound to his credit but in reality tends to disrupt the service. This plan gives an unvarying system, a consecutive and unchanging policy by which steady improvement can be maintained. It is in marked contrast to the obsolete shifting services, the chief changing every three to six months, a policy which, unfortunately, even now may be seen in a few

*Chairman's address, read before the Section on Surgery, General and Abdominal, at the Seventy-Fourth Annual Session of the American Medical Association, San Francisco, June, 1923.

1. Pool, E. H., and Bancroft, F. W.: Systematization of a Surgical Service, J. A. M. A. **69**: 1599 (Nov. 10) 1917.

otherwise modern hospitals. In some of our large hospitals there seems to be a revulsion of sentiment among the younger members of the staffs against the continuous service; this is due partly to a wholesome feeling of unrest, but chiefly to selfish motives, that is, undue eagerness to advance. Those who have worked under both methods recognize that there is no comparison on the basis of efficiency, and that reversion to the shifting services would be a sacrifice of the institution to placate a small number of unduly restless and dissatisfied individuals. The present method, however, means the subordination of the individual to the welfare of the whole. It demands team play, not individualism. This is the keynote of the highly developed modern service. In a service of from sixty to seventy surgical beds, five graded attending surgeons can effectively function with routine duties outlined according to position. This ideal can be accomplished by making the work worth while, making it impersonal, and allowing individual expression and initiative. Two or more similar services with men in corresponding positions in each service afford the necessary competition as regards both excellence of work and promotions.

STAFF CONFERENCE

The staff conference is an essential feature, and is preferably held once a week. The week's work is analyzed, all unfavorable results being reported and discussed. The conference must be brief and impersonal, and speech free; moreover, the work of the senior members of the staff must be subjected to the same criticism as that of the juniors. A definite order of business is followed. For instance,

1. List of operations.
2. Diagnostic errors.
3. Casualty record (deaths, pneumonias, infections, hematomas, phlebitis).
4. Follow-up analysis.
5. Committee reports:
    1. Operating room, first Friday.
    2. Follow-up system, second Friday.
    3. Dispensary, third Friday.
    4. Records and case histories, fourth Friday.

    Other standing or special committees.
6. Unfinished business.
7. New business.

A large amount of work can be covered in a short time because uncertain points and discussions are referred to individuals or committees to decide and report at the next conference. The conference is thus a clearing house, not a forum.

Regularity and punctuality are essential. If the seniors conform, no trouble is likely to arise. If they presume on their positions and assume prerogatives not granted to their juniors, the latter will adopt the same lax methods. Conferences will then either terminate acrimoniously or quietly peter out. Some sacrifice is necessary, and all must hold this duty sacred and dedicate the necessary hours once a week to this branch of the service. With us, the conference is held each Friday from 12 to 1, and general rounds are made from 2 to 4. A long, tiring period is thus avoided, and the staff luncheon from 1 to 2 offers an opportunity for informal discussions.

Certain features of the conference warrant elaboration, notably, diagnostic errors and follow-up system, and it is on these that I wish to dwell.

DIGNOSTIC ERRORS

The rule of the division requires that a single diagnosis be made prior to the beginning of every operation. This diagnosis is written by the anesthetist on the anesthesia slip. At the end of the operation, the correct diagnosis is recorded. Occasionally, this final diagnosis must be deferred until a report is returned by the pathologist after study of the tissue removed. In rare cases, no accurate diagnosis is possible; but the course of the disease or the information gained through the follow-up system sometimes clears up such uncertain cases. All diagnostic errors are discussed at the weekly staff conferences.

It is found that the "single diagnosis" rule stimulates interest, careful observation and thoughtful study of cases. The single system, though more difficult than the multiple or percentage diagnosis systems, has seemed to us better, since it leads to greater efforts toward accuracy.

Although comparison of the first and last years of the system shows that improvement has occurred, the results are still far from what could be desired. An analysis and classification of the errors has been undertaken in the hope that such a study may suggest means whereby greater accuracy can be attained.

The figures show to what extent patients were operated on in whom no lesion was found to justify operation. They emphasize the cases in which error depended on an incomplete history, incomplete examination or imperfect deductions. But the particular interest in the analysis of such a series is that it demonstrates the types of cases in which mistakes are frequently made. For instance, seven out of a total of fifty-seven cases of perforated ulcer of the stomach or duodenum were wrongly diagnosed. In this connection it is often said that the correct diagnosis of a perforated ulcer can be made over the telephone. That is true in most cases, but in some there is little to suggest it. Thus, a man, aged 49, admitted thirty-six hours after the onset of the attack, gave a history of severe, continuous abdominal pain, first in the upper part of the abdomen, then generalized. He had had obstipation for four days and frequent vomiting. The temperature was normal; leukocytes, were 17,000, and polymorphonuclears 89 per cent. There was no distention or rigidity, but some tenderness over the region of the pancreas.

Striking mistakes are noted under the diagnosis, "chronic appendicitis"; in acute appendicitis there were twenty-one errors in 1,058 cases.

The fact that in all the eight cases of acute pancreatitis the diagnosis was missed is a stimulus toward more careful study of the clinical picture in connection with this lesion. In eighty-one cases of ectopic gestation the condition was wrongly diagnosed in twenty-three; moreover, the diagnosis of ectopic was made in twenty-two cases in which ectopic was not present. However, all cases of ruptured ectopic were correctly diagnosed. Such examples might be multiplied. In ectopic gestation and pancreatitis it has been shown that relatively numerous mistakes were made. Such findings should direct greater attention to the study of cases of these types and lead to greater accuracy in diagnosis. The analysis likewise demonstrates peculiarities or leanings of an individual operator; for instance, one man twice made an incorrect diagnosis of hypernephroma, once in an appendix case. The same operator repeatedly diagnosed gastric ulcer in cases in which there was

none. After his attention was called to these slips, he made fewer errors in such cases.

The importance of a thorough examination has become clear. Our rule is that the operator must examine his patients, other than emergencies, on the day before operation. This acts as a check on the history, physical examination and tests, any of which, if found imperfect, may be completed before operation. If this rule is conscientiously followed, patients will not be operated on with scant consideration; due thought will be given as to the operative procedure and necessary rest and preparation will be insured prior to operation. Cancer of the rectum will not be served up as hemorrhoids; abscess of the prostate or multiple polyposis of the colon will not be overlooked through neglect of a rectal examination; the diagnosis and operative resistance will not be left to the judgment of an immature house officer, or the operation casually planned on the telephone without seeing the patient. Yet many mistakes are made in spite of reasonable care and effort. Some of them appear, in cold retrospect, impossible and unwarranted. Moreover, errors dependent on incomplete physical examination even now are recorded.

As has been stated, improvement has occurred with progressing years. Greater efforts are now made. There is often much discussion as to cases of doubtful diagnosis and considerable figuring and thought is given to the establishment of a correct diagnosis. In hernias, differentiation between direct and indirect is usually made without mere guessing. In 487 direct hernias, forty-eight errors were made; in 1,007 oblique hernias, there were forty mistakes. The mistakes in hernia, that is, an oblique inguinal hernia being mistaken for a direct, and vice versa, are of academic rather than of practical interest. Operation must be undertaken in either case. But the effort to differentiate the type adds an interest to an otherwise dull subject and necessitates careful examination of all cases before operation, and this, we believe, should be insisted on.

FOLLOW-UP SYSTEM

The follow-up system and end-result analysis are of vital importance.

By end-result is meant the ultimate outcome in respect to general health, symptomatic relief, anatomic condition of the parts affected and economic efficiency of the patient, especially the period and degree of disability.

This information is obtained through the follow-up clinic. We find a weekly Sunday morning clinic best, since the working classes are then free. Two attending surgeons, three members of the house staff and one nurse serve each Sunday from 10 to 12. All patients are examined three months after discharge, and thereafter as often as is indicated.

In 1922, after eight years' experience with the system, there were followed 86.8 per cent. of the 2,996 patients whom we tried to trace; 71.5 per cent. of the whole number reported in person; 15.3 per cent. were heard from either by letter or by report from a social service nurse.

Some of the advantages are that the examinations often result in timely advice; and failures or complications are recognized and corrected early.

The failures are discussed at the weekly conference and the aggregate gathered from month to month. A mass of material rapidly accumulates which can be made of great value if carefully classified and studied. The failures are often disheartening because exact figures give to the poor results a far more conspicuous place and a far higher percentage than is derived from impressions. Convenient forgetfulness becomes impossible. Yet such facts show up one's weaknesses and thus stimulate the conscientious worker, whose work from year to year as a direct result becomes more reliable and careful. The grouping and analysis of results should be carried out by the allotment of subjects to men on the staff and to outside workers who are interested in special subjects.

Such group analyses, when collected from a number of clinics so that convincing statistics become available, will ultimately clear up many of the uncertainties of surgery. For instance, the amenability or resistance of various doubtful lesions to surgical efforts; the relative merits of roentgen-ray treatment and surgery in exophthalmic goiter, as well as the indications for surgery and radium in types of malignant growths.

The fact that these studies are not conducted in the laboratory and are not experimental in nature have caused them to be viewed as less attractive than pure research and even the product of an inferior type of mind; but such studies on the basis of truths attained may be fairly balanced against most of the results that reward the time-consuming efforts of the average research worker.

Through the follow-up system, then, the surgeon becomes more proficient. As surgery improves, the community is benefited by curtailment of economic waste; the institution profits in respect to turnover, and patients, present and prospective, for whom, on last analysis, all efforts are directed, gain greatly.

COMMENT

A warning must be sounded lest any system becomes a fetish and figures and records be reverenced for their own sake. They are of value only if used, or if susceptible of use. Experience, however, indicates that such records, if accurate and full, constitute a mine of valuable information. At the end of five years, we began to summarize results. The gynecologic material with history, operative findings and follow-up has been culled over so much that we have some information on such features as the effects of leaving an ovary in hysterectomy, and the contrast between delayed and immediate operation in cases of ruptured ectopic gestation in shock.[2] Among general subjects studied are recurrences and complications after herniotomy,[3] the fate of necrosed bone in osteomyelitis,[4] and late results of gastro-enterostomy.[5]

Exchange of ideas in the form of frequent consultations between medical and surgical staffs is a desideratum, but a difficult feature to bring about. In New York, surgeons are usually active in the morning hours, medical men in the afternoons; consequently, meetings are often difficult. This is probably the weakest detail of our system; fortunately, the same difficulties do not prevail generally.

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2. Hawks, E. M.: The Ovary After Hysterectomy for Fibroids, Am. J. Obst. & Gynec. **1**: 959 (June) 1921; Immediate Versus Delayed Operation in Cases of Collapse Following Ruptured Ectopic Pregnancy, Surg., Gynec. & Obst. **36**: 232 (Feb.) 1923.
3. Erdman, S.: Inguinal Hernia in the Male, Ann. Surg. **77**: 171 (Feb.) 1923.
4. Bancroft, F. W.: The Fate of Necrosed Bone in Chronic Osteomyelitis, Tr. Sect. Surg., General and Abdominal, A. M. A., 1922, p. 154.
5. Pool, E. H., and Dineen, P. A.: Late Results of Gastro-Enterostomy for Gastric and Duodenal Ulcers, Including Acute Perforated Ulcers, Ann. Surg. **76**: 457 (Oct.) 1922.

Many important features, such as record system and dispensary, have not been discussed, since they pertain to hospital management rather than to the management of a surgical service. Yet the importance of close cooperation between the outpatient department and the wards must be emphasized, for the dispensary both feeds and drains the wards.

Pathology being the basis of surgery, regular conferences must be held to stimulate and instruct. Moreover, they act as a close bond of union between the clinical and laboratory units. An exchange of ideas and knowledge results, not merely the usual exchange of a bit of tissue for a paper slip. It may appear incongruous for the mature surgeon to sit in with his young staff and be instructed on gross specimens by a youthful pathologist and to observe under the microscope sections of syncytioma, chordoma, myeloma, adamantinoma or the nodes of Hodgkin's disease. But if that surgeon does not know these pictures, he is not too old, if working, to learn them; if he does know them, that fact will be a stimulus to his younger colleagues.

It is surprising that the managers of hospitals have not shown more interest in, or even knowledge of, such contemporaneous efforts to promote professional economy and efficiency. These matters are of interest not only to the patient, surgeon and science, but also to the institution. Yet governors or trustees are, for the most part, ignorant of the fact that efforts of the sort described are being made. The reason is that the average professional and lay boards are separated by an impassable quasisocial barrier which precludes a free exchange of ideas and cooperative efforts. When this barrier is removed, and this can be done only through the initiative of the lay board, conditions in a hospital are more progressive, harmonious and effective because all shoulders are impelled to push the wheels in the same direction and in cooperation.

CONCLUSION

It should be emphasized that in any effort toward systematization, the physical mechanism and duties alone must be regulated, not the spirit and thought. A routine, inelastic mode of treatment, an inhuman, mechanical attitude toward the patients especially should be avoided. Developments or changes should be in the nature of an evolution, being incorporated as far as possible with existing customs; the disturbing upheavals of revolutionary methods should rarely, if ever, be employed.

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The Antiquity of Disease.—Pathologic conditions among fossil animals are known as far back in geological time as the early Paleozoic; hence it may be proper to state on the basis of our present knowledge that disease began among both plants and animals at this time. One of the oldest known evidences of pathologic conditions among fossil animals is found in the enlarged stems of fossil crinoids, which have been known for many years. They were described by Robert Etheridge, from the Carboniferous of Scotland. Five years later a correct interpretation of these deformities was given by L. von Graff. He showed, on the basis of similar enlargements among recent crinoid stems, that these enlargements were due to the parasitic action of myzostomids. Graff supported his interpretation by describing the carbonized remains of some worm to which the tumor was due, preserved in a channel of one of the fossil lesions.—Moodie: The Antiquity of Disease, University of Chicago Press, 1923.

ROENTGENOGRAMS OF THE FETAL SKELETON AS A POSITIVE SIGN OF PREGNANCY*

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The positive signs of pregnancy are those objective signs referable to the fetus appearing after the quickening, any one of which can definitely establish the diagnosis of pregnancy. They become positive only when elicited by the examining physician, to wit: (1) the fetal heart tones, heard by the physician; (2) fetal movement, felt by the physician, and (3) fetal parts palpated and differentiated by the physician. Some of the recent textbooks, such as that of De Lee, mention roentgen-ray examination of the fetal skeleton in the last trimester as an additional sign, but place very little emphasis on its value or range of usefulness. A final sign, the presence of chorionic villi in uterine scrapings, is also a positive sign, but obviously does not concern us in this presentation.

Granted that the fetal roentgenogram is a positive sign, what is its practical value? Several articles have appeared on this subject within the last few years, but we find that the latest works on the roentgen ray are still skeptical as to the possibility of clear fetal shadow; for instance, Tousey[1] says: "The fetal head shows well when it occupies the lowest part of the uterus, . . . but when it occupies the fundus, the surrounding fluid produces so much dispersion as to make radiography unsatisfactory. The fetal bones are small and almost cartilaginous, so that it is difficult to distinguish them in a radiograph before birth." We held a somewhat similar view until about a year ago, when by reason of two generous grants we were able to begin a systematic investigation in this subject. We are now able to show the whole fetus on the film, even to the extent of hands, feet, orbits, sphenoid sinus and sella turcica, under favorable conditions. The hands and feet of the fetus are clearly visible in some of our films at about six months.

We feel that in the last trimester the fetus can quite regularly be clearly demonstrated so as to be helpful, convincing, corroborative, and even solely diagnostic in puzzling and atypical circumstances which present themselves to the obstetrician. The following cases are illustrative:

CASE 1.—A girl, aged 15, was recently brought to the office of one of our surgeons for diagnosis. He suspected from the symptoms that she was pregnant, and examination of the abdomen revealed a symmetrical tumor reaching as high as the umbilicus. Both the girl and her mother stubbornly denied the possibility of pregnancy, and the latter, incensed at such an insinuation on the part of the physician, threatened to bring suit against him for defamation of character. The doctor referred the girl to us for a roentgen-ray examination, and when the full fetal skeleton on the film was shown to the girl's mother, her wrath cooled, and she made the necessary provision for her daughter's confinement.

When an attempt is made to conceal pregnancy, wilful or otherwise, the roentgen ray supersedes all other positive signs, and is convincing beyond further question.

* From the Adolf Stein Memorial for Research in Roentgenology. This work was supported by a grant from the Otto Baer Fund for Clinical Research.

1. Tousey: Medical Electricity and Roentgen Rays, Philadelphia, W. B. Saunders Company, 1921, p. 1067.

CASE 2.—A few months ago, a woman, aged 21, who said that she was in the last month of her pregnancy, consulted us because she menstruated through her pregnancy. She felt fetal motion, and the physician who had cared for her told her that he had heard heart tones (?) for the last two months. She gained 50 pounds (23 kg.) in seven months. Examination disclosed an obese young woman with a normal, nongravid uterus, and no signs of pregnancy. It was clearly a case of pseudocyesis, but this patient was not to be convinced by a statement from us after a single examination, when on repeated examinations by her physician she had been assured that she was pregnant. A roentgenogram, however, soon convinced her by its total negative result that she might cancel her hospital reservation and indefinitely postpone engaging her nurse. On a regimen of diet and exercise she rapidly lost her excess adiposity.

Case 3, reported to the Chicago Gynecological Society in January, 1923, demonstrates the corroborative value of roentgenograms in pregnancy.

CASE 3.—Mrs. M. G., a primipara, aged 19, entered the Michael Reese Hospital, Dec. 30, 1922, in her thirty-sixth week because of rupture of the membranes. She was kept quietly in bed under observation. A roentgenogram on admission clearly showed a well flexed fetus in right occipito-anterior presentation, with the head floating. Liquor continued to escape freely for the next few days, and the uterine tumor shrank considerably. January 3, the fourth day after the rupture of the membranes, the patient said that the baby was unusually active and that she was having regular contractions about every ten to twelve minutes. External examination now revealed a hard, round, ballotable body in the right fundus, and a breech presentation was diagnosed. A second roentgenogram showing a breech presentation corroborated the diagnosis of spontaneous podalic version. She was delivered the same night, there being a double footling presentation, and practically no liquor accompanying the birth.

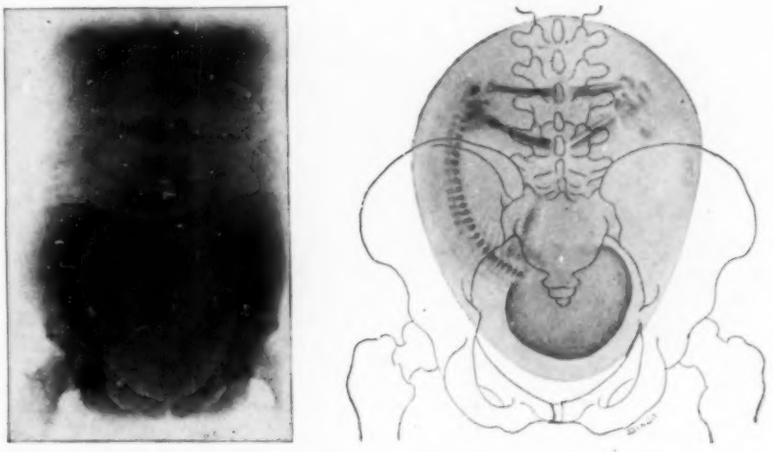

Fig. 2.—At left, appearance in cephalic presentation, at six months from reduced print, not retouched; at right, wash drawing made from the film.

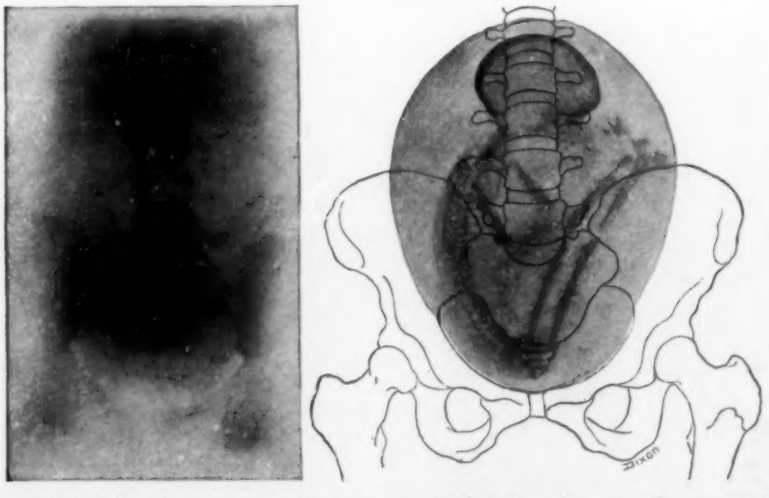

Fig. 1.—At left, roentgenographic appearance in single breech presentation at seven months, from reduced print of film, not retouched; at right, wash drawing from original film.

It is almost incredible that in a primipara the fetus will change from the normal cephalic to a breech presentation three days after rupture of the membranes and in the first stage of labor. This change of polarity can only be attributed to fetal movement, for gravity certainly played no part, as the patient was quiet in bed, and adaptation would favor the original relationship. To report such an observation would be folly without the roentgen-ray corroboration. As verified by the roentgenograms, this case report is unique.

In the checking up of deflexion attitudes and suspected transverse, breech and oblique presentations, and for verifying occiput posterior positions, not always easily recognized clinically, judging from the numerous surprises encountered in the maternity from this dreaded position, the roentgen ray is of great value.

In breech presentation the complete is readily differentiated from the incomplete varieties, Figure 1 clearly showing a single breech. Stereoscopic films of pregnancy at term show not only the relation between the fetal head and the bony inlet, but also bony anomalies, and give a birds-eye view of the bony birth canal.

PSEUDO-STEREO GLASS

An aid in the study of roentgenograms is the ordinary reducing glass, or biconcave lens. In utilizing the glass for condensing small, vague, fetal bony shadows, we observe that the image stood out with increased clarity. It acquires depth and perspective as do films in the stereo shadowbox. A roentgenogram of the bony pelvis viewed through the reducing glass appears like a stereoroentgenogram, and the whole fetus seems to stand out as though mounted in glass. In visualizing the bony pelvis and in differentiating various positions of the fetus, the lens has proved most useful to us. We urge the utilization of the biconcave lens in the study of skull, chest, abdominal and pneumoperitoneum films, as well as those in pregnancy. Although the effect is pseudostereoscopic, it does not detract from its value in studying single films and plates.

We wish to sound a note of warning concerning the interpretation of the size and age of the fetus from the shadow cast on the film. The unstable positions of the fetus, and the distance of the parts from the film, produce shadows of different size and intensity. Figures 3 and 4 illustrate the difference produced in a full

term fetus with the patient in the prone and the dorsal postures. In the case of a primiparous breech presentation we were confused by the roentgenogram to the extent of making preparations for craniotomy on the after-coming head. We were sure we were dealing with a hydrocephalus. Both dorsal and lateral views showed a skull enlarged out of all proportion to the rest of the fetus. A normal baby was readily delivered some hours later, with only the usual difficulty with the after-coming head. The fetal posture was responsible for the aberation.

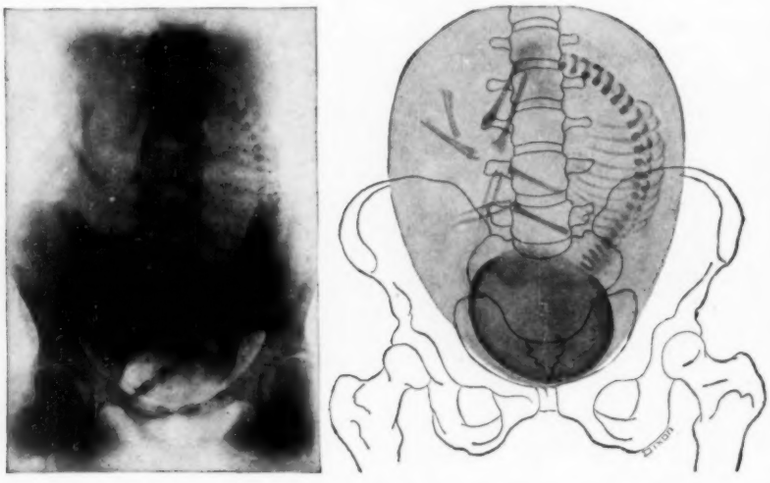

Fig. 3.—Appearance in normal cephalic presentation, full term, with subject in prone position.

At six months we can almost invariably demonstrate a clear fetal shadow (Fig. 2) when the differential diagnosis between pregnancy and fibroids, ovarian cyst, obesity, ascites, pseudocyesis and menopause can be made with certainty. From six months to term our results are now constantly satisfactory. The most gratifying results in our series, however, were when the patient presented a tense abdomen with the fundus reaching higher than the estimated month of pregnancy would warrant, and in whom abdominal palpation gave little or no information as to the uterine content. In several of these we demonstrated twins by the roentgen ray (Fig. 5). The presence of hydramnios, which is usually associated, is liable to interfere with a clear fetal shadow. A change in the posture of the patient, however, will aid in clearing the situation. For instance, in the dorsal posture one head may be seen in the inlet of the pelvis, and the other so distorted and diffused as to be obliterated on the film. A second, lateral view may show the other head in the uterine fundus. The differential diagnosis between twins, monstrosity and hydramnios with a normal fetus can usually be made. No monstrosities were seen in our series of more than 400 cases, but Case [2] demonstrated the possibility of recognizing anencephaly by roentgen ray in 1916. Triplets were demonstrated on the roentgenogram by Möller [3] in 1920. Peterson [4] recently reported the verification of a full term abdominal pregnancy by the roentgen ray.

2. Case, J. T.: Surg., Gynec. & Obst. **24**: 312 (March) 1917.
3. Möller, E. E.: Gynéc. et obst. **2**: 145 (Sept.) 1920.
4. Peterson: Personal communication to the authors.

In his report of 250 cases in which the roentgen ray was employed in pregnancy at the Chicago Lying-In Hospital, Horner [5] stated that his youngest fetus was one of five months. He felt satisfied that the fetus could not be demonstrated before quickening. In the discussion of his paper before the Chicago Gynecological Society, we demonstrated the roentgenogram of a dead fetus in utero estimated to be one of from four to four and a half months. Quickening had not been experienced by the mother, and repeated examinations by us while the patient was in the hospital under observation failed to reveal signs of life. Until recently, this was the youngest fetus demonstrated in our series.

A patient was referred to us, April 6, 1923, from the gynecologic dispensary with the diagnosis of suspected ectopic pregnancy. She gave a history of irregular bleeding with the last regular period, January 5. In the last week of January she complained of the subjective symptoms of early pregnancy. April 4, the patient spotted and complained of sharp pain in the left pelvis.

Our examination the following day revealed a uterus enlarged to about the size of a three months' pregnancy, with tenderness to the left but no adnexal mass palpable. To rule out the possibility of an ectopic pregnancy, a transabdominal pneumoperitoneum was done by the Peterson technic, a liter of carbon dioxid being introduced. The roentgenogram revealed a definite intra-uterine fetus (Fig. 6), which we demonstrated to the Rock Island (Ill.) County Medical Society, April 10. One can readily distinguish above the uterine isthmus shadow the fetal head with the face in profile and an arm raised above the head, the humerus, radius and ulna appearing very distinct. The orbit, maxilla and mandible are visible, and, just below the face, several ribs which appear like fish bones. A considerable number of the spinal vertebrae are visible, and the pelvic girdle faintly so. One femur is distinct in flexion.

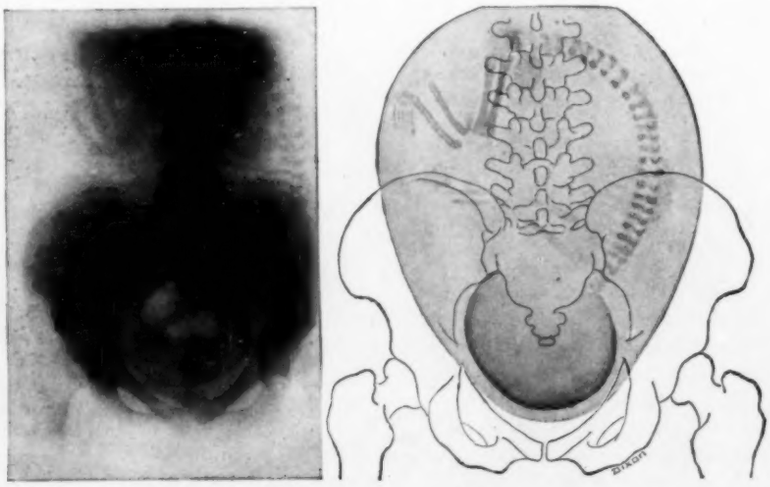

Fig. 4.—Appearance in normal cephalic presentation, full term, with subject in dorsal position.

The exact age of this fetus cannot be determined at this writing, but will be checked back when the patient delivers. The roentgenogram was taken three weeks before fetal movement was demonstrated, and about the same time before quickening occurred. We believe that this fetus was between three and four months,

5. Horner, D. A.: Surg., Gynec. & Obst. **35**: 67 (July) 1922.

probably of about fourteen weeks' gestation. Hess'[6] description of the osseous development of from thirteen to sixteen weeks corresponds to our case.

The uterus in early pregnancy can be demonstrated by pneumoperitoneum and is quite typical of gestation;[7] but only when the fetal skeleton can be demonstrated on the film does the roentgenogram become a positive sign of pregnancy.

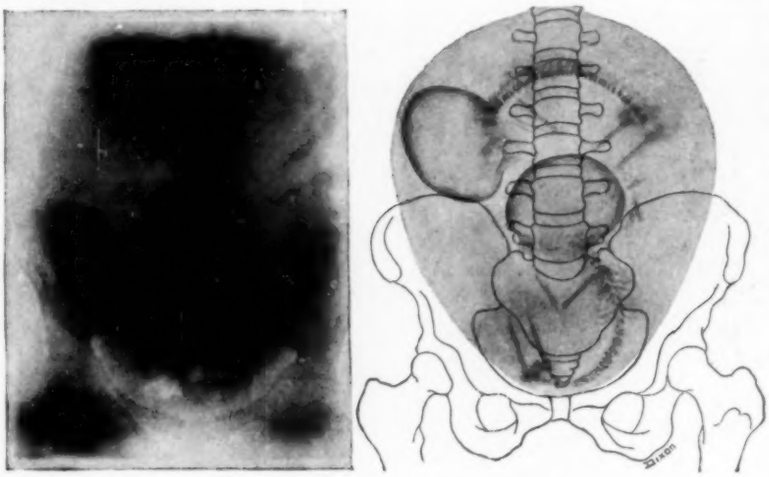

Fig. 5.—Twins, eight months, transverse over breech: at left, from reduced print, not retouched; at right, wash drawing made from film.

According to Edling,[8] early in the third month it is possible to obtain good roentgenograms of the fetus. Edling's short article is not illustrated, nor does he describe such early fetuses. Kuegle[9] reported that he had demonstrated a three months fetus by the roentgen ray, and he was of the opinion that no difficulty should be encountered in showing the three months fetus in a high percentage of cases. His article was illustrated, but nothing could be seen in the reproduction of his film. He said: "The two femora are clearly shown, as are also *the umbilical cord and the placental attachment*" (italics ours). We believe that this requires no comment. With a painstaking technic we have been unable to demonstrate the fetus with regularity before five months. In only three cases of more than 400 do we feel sure of a fetus before quickening. However, in these three we have demonstrated the one positive sign of pregnancy obtainable before quickening.

The technic of obtaining satisfactory fetal roentgenograms so that one can be assured of a high percentage of satisfactory exposures was a difficult problem to work out, not only on account of the inherent difficulties of exposures due to inability of the patient to cooperate and the thickness of the parts to be roentgenographed, but also on account of the varied and numerous positions of the fetus in the uterus. Taking up these difficulties in the order mentioned, we must consider first the inability of the patient to cooperate. It is well known that immobilization of the diaphragm by suspending respiration is of the utmost importance, since diaphragmatic excursion imparts motion to practically all of the abdominal contents. It is surprising how many women are absolutely unable, or do not understand how, to hold their breath. This difficulty is increased by an additional respiratory embarrassment due to a pregnant uterus, becoming more so as the patient approaches full term, when a condition of mild asphyxia is often present. Every patient should be taught before an exposure is made just how to hold her breath. Unless the patient cooperates, it is useless to proceed. Once this has been accomplished, the only other interference will be that of fetal movement. This factor offers a real difficulty, and often prevents a satisfactory result. The difficulties of obtaining a satisfactory roentgenogram of any anatomic structure increases progressively with the thickness of the part. The average pelvis, as measured anteroposteriorly, measures from 18 to 25 cm. In the later months of pregnancy, this anteroposterior dimension increases to 40 or 45 cm. Added to this, the thickness of the uterine wall, and the large amount of amniotic fluid present, which in itself offers a tremendous resistance to the ray, plus the production of a large number of secondary radiations, increase the difficulty of properly exposing films.

If the position of the fetus were the same in every instance, it would be a simple matter to roentgenograph every patient from the same angle. This, however, is not the case, and one must consider the tremendous distortion produced in fetal shadows cast on the film of whatever part happens to be farthest away from the film surface. If all the structures lie in a plane, or very nearly so, parallel to the surface of the film, then one exposure in this position should bring out all the parts with uniform sharpness. The fact is, however, that not all the fetal parts are in a plane parallel to the film. For instance, the head with the patient prone may be 10 or more centimeters closer to the plate than the fetal pelvis. In this case, the head would be sharply defined, whereas the fetal pelvis may not show on account of its distance from the film and its subsequent distortion and diffusion. This distortion may be so great that if only one position were used constantly it would be possible to overlook twins. It has been our

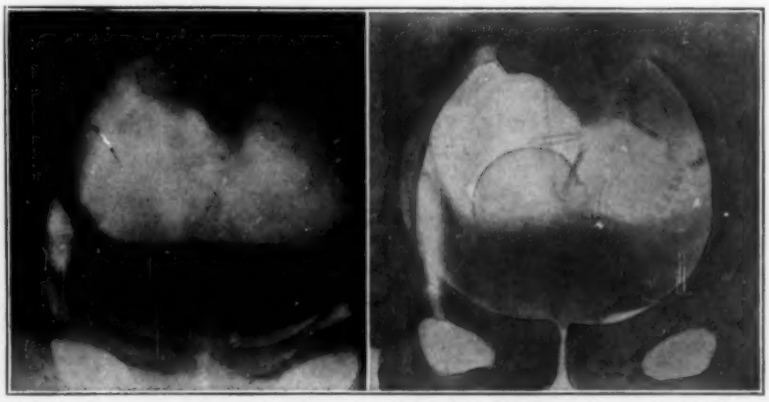

Fig. 6.—Fetus three weeks before quickening; pneumoperitoneum: at left, direct print from film; at right, wash drawing of shadow on film.

6. Hess, J. H.: Ill. M. J. **33**: 73 (Feb.) 1918.
7. Peterson, Reuben: Value of Pneumoperitoneal Roentgenography in Obstetrics and Gynecology, J. A. M. A. **78**: 397 (Feb. 11) 1922
8. Edling, Lars: München. med. Wchnschr. **58**: 567, 1911.
9. Kuegle, F. H.: J. Radiol. **2**: 16 (March) 1921.

practice, therefore, to roentgenograph every patient in both the dorsal and the prone position, and often in the right and left lateral positions as well. In many cases, only by a careful analysis of these four positions were we able to come to a definite conclusion.

The technic that was finally evolved was worked out on the basis of exposure, depending on the thickness of the maternal abdomen, each patient being measured

Technic

Milliamperes	Voltage Between Point Gaps	Time, Seconds	Plate Target Distance Inches	Thickness of Part Inches
WITH EASTMAN DUPLITIZED FILMS				
20	7	8	28	10
20	7½	8	28	11
20	7½	10	28	12
20	8	10	28	13
20	8½	10	26	14
20	8½	11	25	15
20	8½	12	25	16
WITH AGFA DUPLITIZED FILMS				
20	5	8	28	10
20	5½	8	28	11
20	6	8	28	12
20	6½	9	28	13
20	7	9	28	14
20	7½	10	28	15
20	8	10	28	16
20	8½	10	28	16½

beforehand, and the technic as outlined in the accompanying table followed. In every case the Buckey diaphragm was used, as well as double intensifying screens with duplitized films.

CONCLUSIONS

1. In the second half of pregnancy, fetal roentgenograms are of definite confirmative value:

(*a*) In recognizing clinically obscure presentations and positions, the roentgenogram clinches the diagnosis.

(*b*) In differential diagnosis between pregnancy and other abdominal enlargements, the roentgen-ray evidence is the deciding factor.

2. By pneumoperitoneum, the gravid uterus can be quite typically shown on the film in the early months of pregnancy. This may be considered a probable sign. Its value in differential diagnosis is obvious.

3. The demonstration of the fetal skeleton by the roentgen ray is the only positive sign of pregnancy possibly obtainable before quickening.

Radiant Energy Within the Body.—In estimating the effects of radiant energy in our cells and tissues, we usually leave out of consideration the presence of a considerable source of it within the body. Lazarus-Barlow found in certain individuals the presence of radiant energy which may be attributed to the taking up of radium emanation. He used the emanation electroscope for its determination and he found this substance especially in the tissues of persons affected by cancer; usually, but not in every case, the cancerous tissue itself was found to be more radioactive than the normal tissues of the same individual. This radioactivity may communicate itself even to gallstones situated in a cancerous gallbladder, while stones found in noncancerous gallbladders are not radioactive. It is difficult at present to interpret these findings; it may be that cancerous tissue of a certain kind is especially liable to retain the emanation. We may also have to reckon with the somewhat more remote possibility that in persons in whom radium emanation is retained in larger quantity, the factors which tend to produce cancer find a more responsive substratum on account of the presence of the radioactive substance. Nothing has to our knowledge been published as to the finding of such a radioactive substance in animal cancers and especially in transplanted tumors.—Leo Loeb: *J. Cancer Res.* **7**:229 (Oct.) 1922.

INFLAMMATION OF THE DEEP CALCANEAL BURSA

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HALSTEAD, KAN.

The name deep calcaneal bursa is selected in order to distinguish the bursa here described from the subcutaneous calcaneal bursa, and yet show the relation of the two bursae to each other.

While dissecting some knees under the supervision of Prof. Hans Virchow, more than twenty years ago, he demonstrated to me the trick of finding inconstant bursae. While dissecting a foot, I found a bursa not described in the anatomies. It lay between the flexor group of muscles of the foot and the long plantar ligament. Subsequent study showed it to be inconstant; in just what proportion of feet it occurs, I cannot say.

This bursa lies under the beginning portion of the abductor hallucis muscle, extending laterally to the point of origin of the flexor brevis digitorum. Beneath it lies the sheath of the tibialis posticus. The flexor hallucis longus and the flexor longus digitorum lie lateral to it. The bursa is separated by these tendons from the long plantar ligament. The bursa is best exposed in the dissecting room by severing transversely the abductor hallucis 2 cm. from its origin. If one

Fig. 1.—Dissection exposing bursa: *a*, *b*, severed ends of the abductor hallucis muscle elevated to show the situation of the bursa, *c*.

carefully raises the severed ends (Fig. 1 *a*, *b*), a bursa may be found. It is usually 1 cm. broad and half again as long (Fig. 1 *c*). Its relation to the os calcis is shown by exposing the bursa and placing a bullet in the cavity and then making a roentgenogram of the foot (Fig. 2). From this it will readily be noted that the sustentaculum tali forms a convenient bony landmark.

At the time these observations were made, they were regarded as merely of anatomic interest. Some years ago, however, I was consulted by a patient with pain and tenderness in the region in which I had previously observed the bursa. The intense character of the pain and the tenderness to deep pressure caused me to suspect that this bursa was at fault. In harmony with this theory, I made an incision into this area and

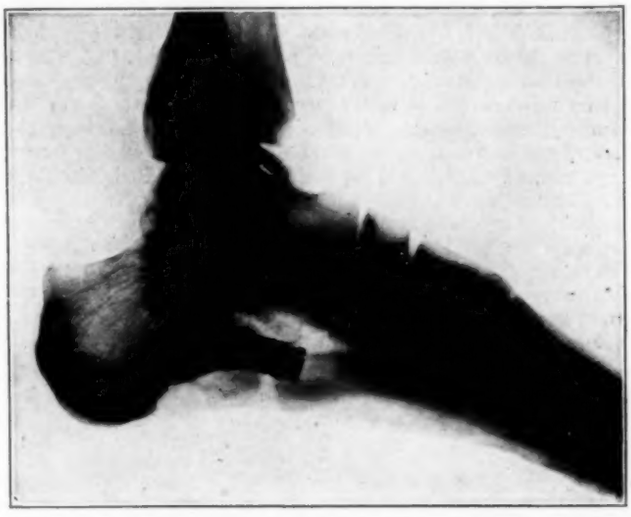

Fig. 2.—A 0.38-caliber bullet was placed in the bursa, after dissection as in Figure 1, and the foot then exposed to the roentgen ray. The bullet lies just below and in front of the sustentaculum tali.

exposed a bursa of the size indicated above. The bursa was curetted with a mastoid curet and drained with a gauze wick, the tip of which was moistened with compound tincture of iodin. Recovery was complete, and she has remained free from pain to date.

Clinically, the disease is characterized by tenderness in the front part of the heel just in front of the attachment of the flexor group of muscles previously noted, and lateral to the sustentaculum tali. The patients do not indicate the exact point in giving the account of their complaint, and they know of no posture that affords relief. It is the pronounced pain on deep pressure over the site of the bursa that is characteristic. There are no other points of tenderness, and the usual signs and symptoms of flatfoot are absent. A number of my patients had been treated by orthopedists under this diagnosis, with merely an increase in the symptoms.

TREATMENT

A line of skin 5 cm. long below the lower margin of the sustentaculum tali anterior to the spine is infiltrated. From this line, the deeper tissues are infiltrated by passing the needle over the long plantar ligament about the tendons of the muscles previously mentioned and into and about the heads of the short flexors. An incision is then made along the line of skin infiltration extending through the skin and fascia just below and in front of the sustentaculum tali.

An elevator is then passed between the sheath of the tendon of the tibialis posticus tendon and the overlying soft parts. The bursa should be reached at a depth of from 3 to 5 cm. Sometimes the bursa cannot be identified because of the presence of the anesthetic fluid in the tissues. Usually, however, the cavity can be discovered easily with the elevator. The site of the bursa is vigorously curetted, even if no definite sac is made out. A small gauze drain is then passed into this area and allowed to remain three or four days. This is for the purpose of continuing the irritation produced by the curet. I formerly used an iodin pack, but so much irritation has been found to be unnecessary.

The treatment has been uniformly successful. The first patient was operated on eighteen years ago, and has remained free from trouble since. A number of others have remained well for more than ten years. Of the twenty or more patients on whom I have operated, not one, to my knowledge, has had a recurrence.

HEREDITARY CLEIDOCRANIAL DYSOSTOSIS

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AND
R. W. BAER, M.D.
FREDERICK, MD.

The rare syndrome of hereditary cleidocranial dysostosis is characterized by defective ossification of the clavicles and the membranous bones of the cranium. The first case was reported by Morand, in 1766, and the second by Barlow,[1] in 1883. It was not until 1898, however, that the affection was brought into prominence by Marie and Sainton,[2] who described the condition under the name of hereditary cleidocranial dysostosis. In 1905, Villaret and Francoz[3] reported an instance of a woman and her three children who were all affected, and compiled forty-one additional cases from the literature. Fitzwilliams,[4] in 1910, observed two cases, and compiled and analyzed fifty-eight others. Langmead,[5] in 1916, reported the occurrence of eighteen cases in four generations, and observed seven of them.

In the family forming the basis of this communication, nine cases have occurred in three generations. Five of these subjects have been observed by us: a father and four daughters. In the father's generation, ten children died and no data concerning them was obtainable. It is probable that some of them were affected. The tenth case was seen by one of us at Bay View Hospital, Baltimore.

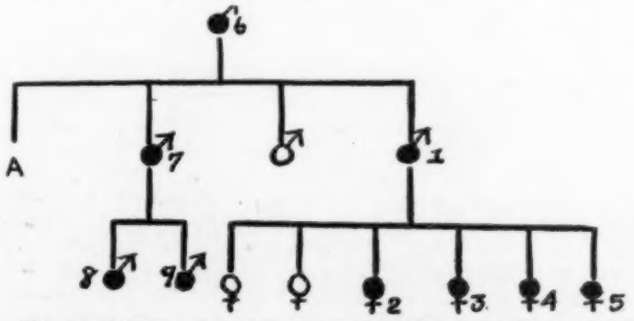

Fig. 1.—Pedigree of family showing hereditary cleidocranial dysostosis: dark symbols, affected members; *A*, ten dead; particulars not known.

REPORT OF CASES

CASE 1.—W. M., a man, aged 58, height 5 feet 6 inches (167 cm.) and weight, 145 pounds (66 kg.), had a large head, of the brachycephalic type, measuring 56 cm. in cir-

1. Barlow, T.: Brit. M. J. **1**: 909, 1883.
2. Marie and Sainton: Sur la dysostose cleido-cranienne héréditaire, Rev. neurol. **6**: 835-867, 1898.
3. Villaret and Francoz: Nouvelle iconographie de la Saltpêtrière **18**: 302, 1905.
4. Fitzwilliams Hereditary Cleidocranial Dysostosis, Lancet **2**: 1466, 1910.
5. Langmead: Proc. Roy. Soc. Med., 1916, Dis. Child., p. 1.

cumference. The fronto-occipital and biparietal diameters were 20 and 16.3 cm., respectively. The sutures and fontanels were closed. There were six prominent bosses on the head, three on each side arranged in pairs, corresponding to the frontal, parietal and occipital bones. Longitudinally, the

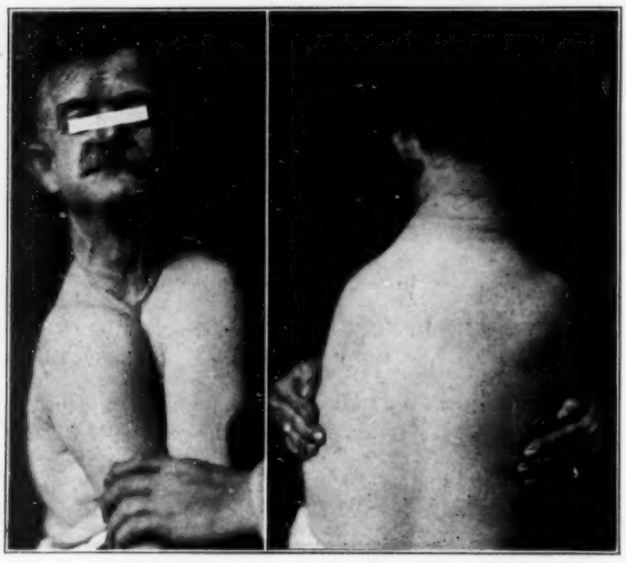

Fig. 2 (Case 1).—Appearance of patient: To be noted are the frontal bosses, median sulcus, overhanging brow, sunken bridge of nose and prognathous jaw.

three pairs of bosses were separated by a wide median sulcus, which was more marked between the frontal bones, and gradually decreased both in width and in depth as it proceeded backward. Two lesser sulci separated the bosses transversely, corresponding to the coronal and lambdoidal

Fig. 3 (Case 2).—Patent sutures and anterior and posterior fontanels.

sutures. The brow was overhanging, the facial bones were small, and the jaw was prognathous. Dentition was late and irregular. The second teeth did not appear until puberty, and decayed early.

The patient's shoulder and neck muscles were exceptionally well developed, no gross anomalies appearing. The shoulders were very slanting, and their position was that assumed in bilateral clavicular fracture. The upper part of the chest was much more conical than normal. A roentgenogram showed the first five ribs to be depressed. The acromial half of the left clavicle was absent; the sternal half was present and well developed. Ligamentous tissue joined the clavicle to the acromion. The middle third of the right clavicle was absent; both the sternal and acromial thirds were rudimentary, the former being represented by a spur of bone 3 cm. in length. The clavicular fragments were joined by ligamentous tissue.

CASE 2.—V. M., a girl, aged 16 years, height 4 feet 10 inches (147 cm.) and weight 88 pounds (40 kg.), had a head of the brachycephalic type. The circumference was 54 cm., the fronto-occipital diameter was 19.3 cm., and the biparietal diameter was 16.3 cm. The sagittal suture and both the posterior and anterior fontanels were patent. The posterior fontanel measured 2 cm. in width and 3 cm. in length; the anterior measured 3 cm. in width and 5 cm. in length. The sagittal suture measured 1 cm. in width between the frontal bosses. The six bosses were very prominent, and the sulci separating them were wide and deep. The bridge of the nose was depressed, the facial bones were small, and the lower jaw protruded. Dentition was late and irregular. The

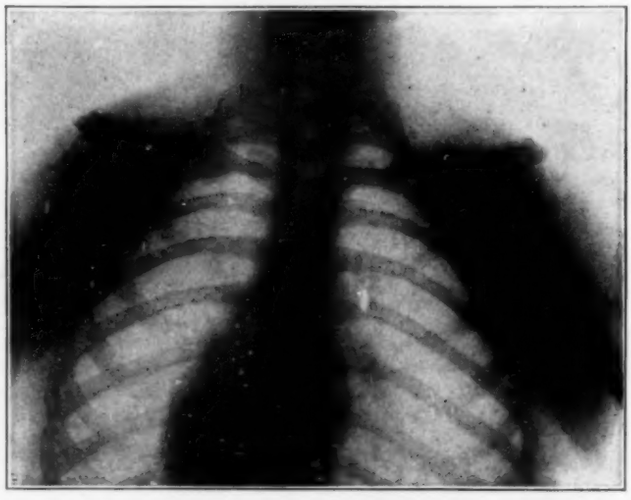

Fig. 4 (Case 2).—Acromial halves of both clavicles missing.

first teeth were retained until puberty. The second teeth were good, and the roof of the mouth was normal.

The musculature of the neck and shoulder girdle was well developed, no abnormalities appearing. The acromial halves of both clavicles were missing. The sternal halves were present and well developed. Ligamentous tissue extended outward from the clavicular ends toward the acromion.

CASE 3.—R. M., a girl, aged 13 years, height 4 feet 8 inches (142 cm.) and weight 75 pounds (34 kg.), had a head of normal size. The circumference was 52 cm., the fronto-occipital diameter was 18.7 cm., and the biparietal diameter was 15 cm. The anterior fontanel and sutures were closed. The posterior fontanel was patent, measuring 2 cm. in length and 1 cm. in width. The occipital bosses were very large. The frontal and parietal bosses were absent. The bridge of the nose was sunken, and the lower jaw prominent. Dentition was late and irregular. The patient retained all of her first teeth. The roof of the mouth was abnormally arched.

The outer fourth of the left clavicle was missing. On the right, nearly all of the clavicle was absent; the middle third was rudimentary, and was represented by two small pieces of bone. A roentgenogram showed the upper right chest to be more conical than the left. The little fingers were very short.

CASE 4.—M. M., a girl, aged 5 years, height 2 feet 10½ inches (87.6 cm.) and weight 27 pounds (12 kg.), had a large and decidedly brachycephalic head. The circumference was 51 cm., the fronto-occipital diameter was 16.9 cm., and the

biparietal diameter was 14.4 cm. The sagittal suture and both fontanels were patent. The anterior fontanel measured 6 by 5 cm., and the posterior 1 by 1 cm. The six cranial bosses were very prominent, especially the parietals. The facial bones were small and poorly developed. The roof of the mouth was normal. Dentition was late and irregular. The patient was poorly nourished and small for her age. The outer third of the left clavicle was absent. The right clavicle was represented by rudimentary sternal and middle portions.

CASE 5.—M., a girl, aged 2 years 6 months, height 2 feet 7 inches (79 cm.) and weight 23 pounds (10.4 kg.) had a brachycephalic head. The circumference was 49 cm., the fronto-occipital diameter was 15.6 cm., and the biparietal diameter was 13.7 cm. The sagittal suture and both fontanels were patent. The sagittal suture measured 1.5 cm. in width between the frontal bones. The anterior fontanel measured 9 by 7 cm., and the posterior 1 by 1 cm. The facial bones were very small. Twelve teeth were present, and the palate was abnormally arched. The acromial third of the left clavicle was absent. On the right, the outer half of the clavicle was absent. The little fingers were short.

We did not see the remaining subjects. The data concerning them were obtained from Patient 1.

CASE 6.—A man, who died at the age of 87, whose height was 4 feet 9 inches (145 cm.) and weight 108 pounds (49 kg.), had no clavicles.

CASE 7.—A man, aged 65, height 5 feet (152 cm.) and weight 110 pounds (50 kg.), had part of a clavicle on each side.

CASE 8.—A man, aged 24, height 5 feet 6 inches (167 cm.) and weight 124 pounds (56 kg.), had part of a clavicle on each side.

CASE 9.—A boy, aged 18, height 5 feet (152 cm.) and weight 100 pounds (45 kg.), had part of a clavicle on each side.

CASE 10.—W. B., a man, aged 52, negro, height 5 feet 5 inches (165 cm.) and weight 145 pounds (66 kg.), had a head of normal size, but it was brachycephalic in type. The sutures and both fontanels were closed. The cranial bosses were quite marked. The facial bones were small, and the lower jaw was prognathous. The outer halves of both clavicles were absent. A roentgenogram showed the upper ribs to be depressed and the upper part of the chest to be more conical than normal. The patient was mentally defective.

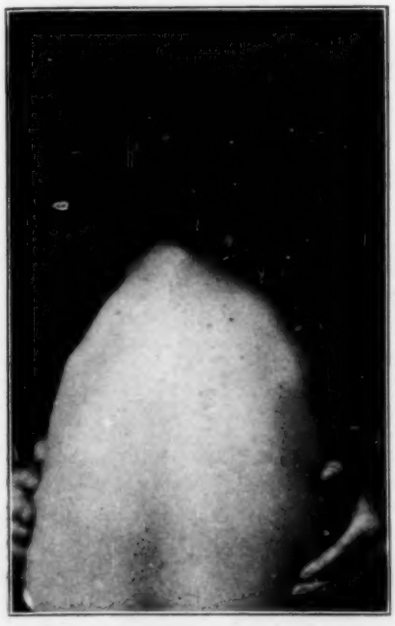

Fig. 5 (Case 2).—View of back.

COMMENT

All of these patients were of small stature. Their heads were relatively large and brachycephalic in type. Closure of the fontanels and sutures was greatly delayed: in one case, at least, until the sixteenth year (Fig. 3). Six more or less prominent cranial bosses were found, corresponding to the frontal, parietal and occipital bones. Sulci corresponding to the cranial sutures separated the bosses. Both the bosses and sulci remained throughout life (Cases 1 and 2). A great number of wormian bones were found along the suture lines (Fig. 3). Roentgenograms showed the sellae turcicae to be normal. The bridge of the nose was sunken and the facial bones were small. The lower jaw was prognathous. Dentition was late and irregular, the first teeth were retained until puberty (Cases 1, 2 and 3). The second dentition was irregular. The palate may be abnormally arched (Cases 3 and 5). The clavicles were defective. The acromial end of the clavicle was usually absent. The remaining portion of the clavicle may be either rudimentary or well developed. The shoulders assumed the position of bilateral clavicular fracture. The upper part of the chest in the older subjects became more conical than normal, and was bilaterally flattened (Cases 1 and 10). This is probably due to the weight of the arms and shoulders pressing on the upper ribs. The general musculature was good. There appeared to be a compensatory development of the neck and shoulder muscles. The patients were not physically incapacitated in any way. Mobility of the shoulders was increased, and they could be forced to meet in the midline under the chin. All of the pateints showed genu valgum. Shortening of the middle phalanges of the toes, mentioned by Jensen, was not present in any. With one exception, they were mentally normal. There were no stigmas of syphilis, and the Wassermann reaction in Case 10 was negative.

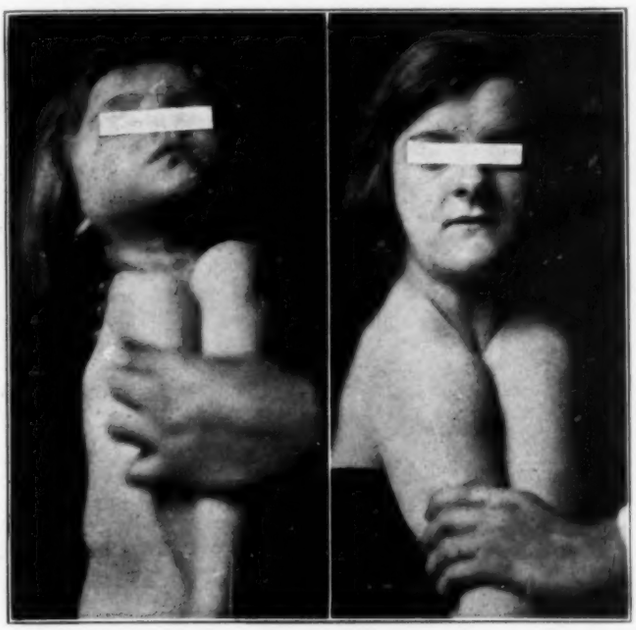

Fig. 6 (Case 2).—At right may be noted the frontal bosses, median sulcus, sunken bridge of nose, prognathous jaw and extreme mobility of shoulders; at left, a hand spanning the shoulders.

Nothing is known concerning the etiology of the affection save that it is hereditary and familial, that both sexes are affected, and that it may be transmitted through either parent.

Masonic Temple Building.

Meat Inspection in London.—During 1922, about 1,800 tons of meat a day passed through the central market of London. One ton in 320 of meat paying toll was condemned, whereas in 1921, one in 169 was condemned. Of the fish delivered at Billingsgate market in 1922, one ton in 107 was condemned, as compared with one ton in eighty-eight in 1921.

A FORM OF POLYPOID COLITIS AS A LATE STAGE OF AMEBIC DYSENTERY

REPORT OF CASE

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CHICAGO

History.—A druggist, aged 41, a patient of Dr. W. H. Burmeister, was admitted to St. Joseph's Hospital, Feb. 12, 1922, complaining of diarrhea, rectal tenesmus, weakness, abdominal pain and insomia. He was a native of the United States and had never lived in tropical or other foreign countries. In 1912, he developed a mild diarrhea with from three to five soft stools daily, which persisted in attacks of a mild form for many years with little or no discomfort. In 1917, attacks of severe diarrhea became frequent; the stools became more watery, and numbered from ten to fifteen daily, and occasionally the patient had abdominal cramps. The diarrhea slowly and progressively became worse until, six months before entering the hospital, he was too weak to work. In

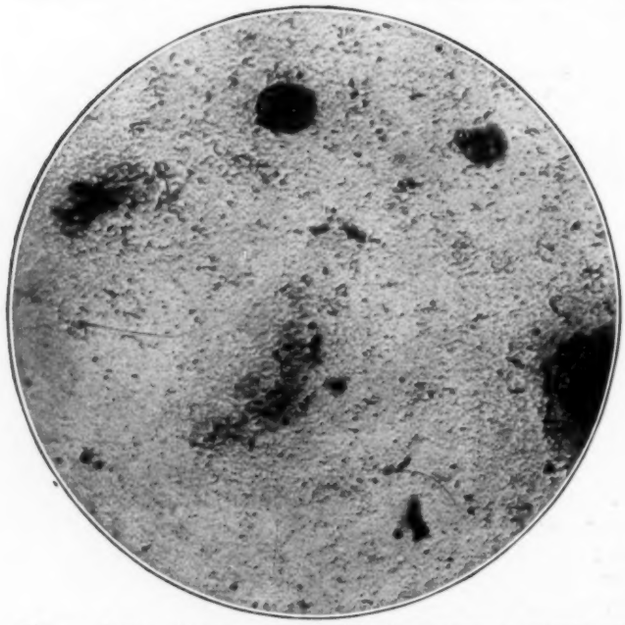

Fig. 1.—Section of colon showing projecting masses of necrotic substance and inflammatory tissue.

November, 1921, there was about one-half ounce of blood on the top of the stool, and, after this, blood was noticed frequently. Various diets did not better the diarrhea, although the patient was more comfortable on a diet of soft starchy or carbohydrate foods.

The patient was well developed but poorly nourished, with pale, sallow skin and slightly protruding eyes. There was slight tenderness in the lower left abdominal quadrant. Rectal examination was negative. A blood examination revealed 81 per cent. hemoglobin; 4,450,000 erythrocytes; 10,200 leukocytes; 64 per cent. polymorphonuclears; 26 per cent. small lymphocytes; 9 per cent. large lymphocytes, and 1 per cent transitionals; a Wassermann test of the blood serum was negative. There was a trace of albumin in the urine and a few hyaline casts. He passed from ten to fifteen dark brown, foul, liquid stools daily, all containing large amounts of mucus. No blood was seen grossly, but erythrocytes and leukocytes were observed microscopically; and the Weber test for blood was positive. No amebas were found, although fresh, warm stools were frequently examined. A roentgenogram of the colon after a barium enema showed a pronounced series of small uniform defects, which gave the bowel from sigmoid to cecum a spongy or wormy appearance. A diagnosis of polypoid colitis was made, and the diarrhea was treated symptomatically with a soft, bland diet, and rectal irrigations of dilute potassium permanganate solution. The patient had been given several intravenous injections of neo-arsphenamin before entering the hospital. No emetin was given at any time. Aug. 14, 1922, a blood examination showed 41 per cent. hemoglobin, and 3,450,000 erythrocytes. He became weaker and more anemic, and died, August 21.

Necropsy.—This was performed four hours after death. The body was 174 cm. long, and weighed about 125 pounds (57 kg.); it was greatly emaciated; the skin and mucous membranes were pale, and the eyeballs bulged slightly; subcutaneous fatty tissue was scanty; the omentum was attached by a narrow fibrous band to the sigmoid colon, which was kinked and located high in the peritoneal cavity; there were adhesions between the sigmoid colon and the lateral abdominal wall; the coils of small intestine were free in the peritoneal cavity. The mesenteric lymph glands were slightly swollen. The mucosa of the small intestine was slightly congested and covered with mucus, but the wall was not thickened. The wall of the entire colon was greatly thickened, from 4 to 6 mm., in all parts except the portion of kinked sigmoid colon, in which the diameter was from 8 to 11 mm. From the lower part of the ascending colon to the distal part of the pelvic colon, the mucosa was studded with numerous confluent dirty gray nodules. The crescentic folds (plicae semilunaris coli) were greatly exaggerated, and covered with similar elevations. Some of the nodules projected into the lumen of the bowel 3 mm., while others were flat. The diameter of the nodules varied from 2 to 6 mm., the base usually being about the same diameter as the top. A thick coat of glairy mucus covered the mucosa. In the pelvic colon the nodules were less numerous and discrete, and none were present in the rectum or pouch of the cecum. The elevations in the greatly thickened portion of kinked sigmoid were wider, and submucosal hemorrhages gave the lining a mottled, purple and gray appearance. No recent or healed ulcers could be distinguished grossly in any part of the colon. There were no ulcers or areas of hyperplasia in the mucosa of the esophagus, stomach or small intestine. Other findings were: numerous patches of fatty changes in the intima of the aorta; patchy sclerosis of the epicardium and endocardium; slight atrophy and fatty infiltration of the heart muscle; early sclerotic changes in the kidneys; fibrosis of the spleen, and slight perisplenitis. There were no abscesses in the liver or any gross changes in the pancreas, suprarenals, testes, epididymides or lungs.

Examined microscopically, the nodular elevations of mucosa were composed of granular necrotic material, inflammatory cells and fragments of intestinal glands. In many of the crypts between the nodules, slight ulceration was present. The surface of the nodules was necrotic, and the fragments of intestinal glands, below this layer, showed advanced stages of necrosis, while deeper in the mucosa the outline of the glands was well preserved, but the cells showed varying degrees of degeneration. The lumen of many of the glands contained desquamated epithelial cells and cellular débris. The thickening in most parts of the intestinal wall was due to the cellular infiltration and edema of the mucosa, but in the sigmoid portion much of the thickening was in the submucosa. Plasma cells and lymphocytes were numerous in the stroma of the mucosa, more abundant in the submucosa, and present in small numbers in the muscular coat. Polymorphonuclear leukocytes were seldom found. In the submucosa and inner muscular coat there were many oval and round ameba-like bodies, from 12 to 14 microns in diameter (the plasma cells in this tissue measured from 3 to 5 microns). Some of the bodies were homogeneous and granular with no visible nuclei, while others contained a poorly defined nucleus, eccentrically placed and containing a karyosome-like structure in the center. Red blood cells were present in some of these bodies. Within the epithelial cells of the intestinal glands there were many small deeply staining bodies from 1 to 3 microns in diameter, some ovoid in shape, others irregular. In some of the glands all the cells contained these bodies; in other glands only a few of the cells contained them, and some were free in the lumen or in the desquamated epithelial cells in the lumen. Some of

the bodies were free in the cell, while others were surrounded by a well defined halo. These bodies were somewhat similar to forms of *Endameba histolytica,* which Jackson [1] found in the kidneys of a child and described as vegetative or schizogonic forms.

COMMENT

Polypoid colitis, colitis polyposa, or enteritis polyposa are names applied to adenomatous growths which project or hang by a stalk from the intestinal mucosa. Usually such masses are composed of numerous, irregular, partly cystic glands of greater length than normal glands and embedded in a loose stroma, which, on account of the traumatism to which it is exposed, is constantly inflamed. The growths are often multiple and sometimes so numerous and small as to give the mucosa a shaggy appearance. The polypoid masses in the mucosa of the colon in this case were not adenomatous, but the result of undermining of the mucosa by an inflammatory process. In the process of healing of dysenteric lesions, similar polypoid masses are often formed at the margin of ulcers. Kaufmann [2] calls attention to their presence in tuberculous ulcerative

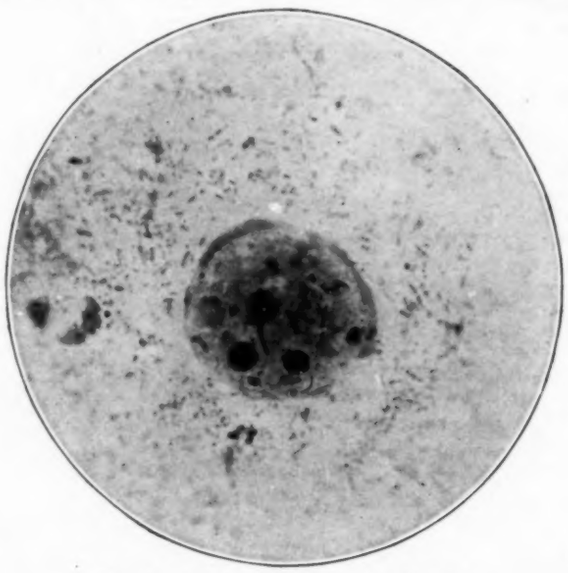

Fig. 2.—Amebas in wall of sigmoid colon.

intestinal lesions, and writers on amebic dysentery describe such nodules as a part of the intestinal lesions.

The earliest changes of the colon in amebic dysentery appear as elevations in the mucosa, with a hyperemic or hemorrhagic zone at the periphery and a central plug of yellowish necrotic material. According to Strong,[3] if a small capillary hemorrhage occurs in the elevation, nourishment of the overlying epithelium is disturbed and erosion and ulceration occur; but if there is no hemorrhage, the nodules increase in size through edema and round cell infiltration. The inflammatory process is essentially slow and chronic; few polymorphonuclears are found, while plasma cells and lymphocytes are numerous. The erosions and simple ulcerations usually heal completely or progress to large suppurative, undermined ulcers whose healing is associated with scar formation and contraction.

The appearance of amebas in tissues is apt to be misleading, because they are likely to degenerate quickly after death. Dobell,[4] in his studies on fresh *Endameba histolytica,* describes the typical ones as actively motile bodies from 18 to 40 microns in diameter, with clear cytoplasm, finely granular endoplasm, indistinct, vesicular spherical nuclei, eccentrically placed and containing a central karyosome. As the nuclear characteristics of dead amebas are not clear cut, he believes that the most serviceable criterion for diagnosis is the presence of erythrocytes in the cytoplasm.

The postmortem diagnosis of amebic colitis in the present case is made on the presence in the intestinal wall of bodies morphologically like *Endameba histolytica,* some of which contain erythrocytes. The chronic inflammatory reaction with a large number of plasma cells, which this specimen presents, is the usual finding in amebic dysentery. In amebic dysentery, however, it is unusual to find a colon with no gross signs of ulceration, but with extensive confluent, polypoid masses that give the mucosa a uniformly shaggy appearance. Councilman and Lafleur,[5] Christofferson,[6] Musgrave,[7] Bartlett,[8] Reed,[9] Wooley and Musgrave,[10] and Harris [11] describe the postmortem findings in large series of cases, but no cases were mentioned that were like this one.

SUMMARY

In a case of amebic dysentery, the colon mucosa presented no gross signs of ulceration, but was the site of multiple confluent polypoid masses.

1. Jackson, Leila: An Ameba-Like Organism in the Kidneys of a Child, J. Infect. Dis. **30**: 636 (June) 1922.
2. Kaufmann, E.: Spezielle pathologische Anatomie **1**: 512, 1911.
3. Strong, R., in Osler's Modern Medicine **1**: 503, 1904.

RESIN DERMATITIS

REPORT OF CASE

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PITTSBURGH

Within the last few years, the number of cases of "trade dermatitis" reported has increased rapidly. This is probably due to a number of factors more in evidence at present than they have been during the past. These factors may be thus classified: (1) the almost universal workingman's compensation acts enacted in most states, whereby the working man is protected against any medical illnesses or accidents which may be caused by his regular occupation; (2) the increased variety of minerals, chemicals and drugs used by the various manufacturers in producing their products, and (3) the increased interest on the part of the employers and medical men to alleviate the causative factors of the so-called occupational diseases that may be caused from trades or occupations.

From the point of view of the dermatologist, we are greatly interested in the unusual diseases of the skin that are related to occupation. Interesting cases [1] are being reported from all sections of the country, and the

4. Dobell, C.: The Ameba Living in Man, 1919.
5. Councilman, W. F., and Lafleur, H. A.: Amebic Dysentery, Johns Hopkins Hosp. Rep. **2**: 393, 189, 1891.
6. Christofferson, D. R.: Zur pathologischen Anatomie d Amöbendysenterie, Arch. f. path. Anat. **223**: 350, 1917.
7. Musgrave, W. E.: Intestinal Amebiasis Without Diarrhea: A Study of Fifty Fatal Cases, Philippine J. Sc., B, **5**: 229, 1910.
8. Bartlett, G. B.: Pathology of Dysentery in the Mediterranean Expeditionary Force, Quart. J. Med. **10**: 185, 1915.
9. Reed, A. C.: Diagnosis and Treatment of Amebic Colitis, Am. J. M. Sc. **164**: 587 (Oct.) 1922.
10. Wooley, P. G., and Musgrave, W. E.: The Pathology of Intestinal Amebiasis, Rep. 32, Dept. of Interior, Bureau of Govt. Laboratories, 1905.
11. Harris, H. F.: Amoebic Dysentery, Am. J. M. Sc. **115**: 384, 1898.

1. Pusey, W. A.: Lacquer Dermatitis, Arch. Dermat. & Syph. **7**: 91 (Jan.) 1923.

so-called trade or occupational diseases are readily being studied, prevented and treated in all branches of medicine. To limit ourselves, we might define trade dermatitis, occupational dermatitis, trade eczema or occupational eczema as names used interchangeably to designate a pathologic condition of the skin due, directly or indirectly, to the individual occupation.[2] Often the dermatologist is called on to treat an apparently benign skin condition that has continuously resisted the usual routine treatments for eczema or dermatitis, only to find the case to be an unrecognized recurrent trade dermatitis.

REPORT OF CASE

G. G., a man, aged 56, married, a violinist, referred to me in June, 1922, for a recurring eruption located on the second and third fingers of the left hand, first noticed the eruption five years before, when he was subjected to the first attack over the areas named. A physician gave him an ointment to apply. The lesions did well until the protection was stopped, after which the eruption recurred. The summer months found the patient free from any eruption. The series of attacks described above recurred each fall and spring months, only to disappear during the summer months which followed. At times, the lesions became infected, fissured and painful, and caused the patient to lose a few days of his routine work. Especially during the last two years, the patient noticed a dry brittleness of the finger nails of the affected fingers only, and an associated dry pruritic scaly eruption about the external nasal orifices. These lesions, however, were not so constant as the finger lesions, but, when present, were more persistent. The patient's occupation required his playing a violin in the orchestra of a local theater from September to April of each year. No history of drugs was elicited, the patient stating that he had not taken any internal medication for years.

At the time of examination, the patient showed the condition pictured in Figure 1. The right hand was free of all lesions except a small pinhead-sized follicular pustule located on the right dorsal index finger. The left hand was entirely

Fig. 1.—Apparent quiescent state: small vesicles on dorsolateral aspect of index finger of left hand; the flatness of the finger nail of the middle (left) finger is noticeable.

free from eruption except for the second finger, which showed on its dorsolateral aspect a fine, discrete, pinhead-sized, vesicular eruption extending from the web of the finger to the most distal joint. The vesicles were clear, tense and fairly deep set, but did not rupture spontaneously. The skin of this area was dry, harsh, thickened and slightly scaly. The adjacent side of the opposite finger showed a similar, less productive eruption. There was a slight, dry brittleness present on the finger nails of the first two fingers, with a marked flattening of the nail of the third finger with numerous striations; and both nails were of a dirty grayish hue. The matrices of all the nails were not affected. The routine dermatologic examination of the body revealed no eruption. Especial attention was given to the webs of the toes, soles of the feet, axillary region and the perineal-crural regions,

Fig. 2.—Recurrence of eruption on exposure to the resin applied as an ointment; on the left middle finger nail are dark, irregular striations.

which were carefully examined and found clean. The possible fungus infection was ruled out by scraping examinations and cultures. As the patient was an ardent admirer of plants, these were carefully investigated, skin tests applied, and negative results obtained. The various local irritants, such as soaps, water, hand lotions and drugs, were investigated with negative results. Because of the continued persistent and repeated eruption, always in the identical regions previously mentioned, a careful examination was made to ascertain whether or not the patient could have feigned the eruption; but after repeated examinations, the possibility of a dermatitis factitia was eliminated. At this point, the patient stated that, about five years before, he had changed the type of violin resin which he had used, and was using a new kind which, at present, he was manufacturing on a moderate scale. This was immediately investigated, and the hands were purposely exposed to cause a recurrence of the eruption, which is shown by Figure 2. It is easily conceivable how the parts exposed should be so affected. In the position of violin playing, it was found, when covering the entire hand with a dark ointment, that the resin dust particles from the bow fell directly over the fingers that show the eruption, because of the prominence of these fingers in the string manipulations and the apparent protection of the underlying fingers.

Laboratory skin tests for primrose, geranium and rambler rose (plants present in the household) were negative. Tests of the urine and stool were negative. Blood examination revealed: erythrocytes, 5,100,000; leukocytes, 7,200; small lymphocytes, 16 per cent.; large lymphocytes, 6 per cent.; polymorphonuclear neutrophils, 71 per cent.; transitionals, 6 per cent.; eosinophils, 1 per cent.; hemoglobin, 85 per cent.

Cultures and scales for tinea were repeatedly negative. Culture from vesicles revealed mixed *Staphylococcus albus* and *aureus*. The blood Wassermann reaction was negative.

Analysis of the violin resin compound disclosed red resin, I, dark resin, F; white resin, W W and pitch No. 1, to employ the trade letters under which they are sold commercially. These special types are obtained from North

2. Stelwagon: Diseases of the Skin, Philadelphia, W. B. Saunders Company, 1916, p. 242.

Carolina. Skin tests of the resin in the compound were negative to red resin, positive to dark resin (+++), negative to white resin, and doubtful as to pitch. The skin tests were controlled on two other subjects with negative results.

CONCLUSIONS

1. Occupational dermatoses are more common than usually thought.
2. Occupational dermatoses are almost always mistaken for, and treated as, an "eczema" or "dermatitis" in a routine way.
3. Resin is capable of producing a dermatitis.
4. Treatment consists of the removal of the cause, which is, by far, the most important factor in obtaining a cure.

5026 Jenkins Arcade.

THE THERAPEUTIC VALUE OF EGG YOLK IN RICKETS*

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Yolk of egg has frequently been employed in the diets of infants, and is brought forward here not as a new food, but rather as a therapeutic agent. Generally it has been resorted to with the purpose of increasing the percentage of fat or the caloric value of the food. Recently, De Sanctis[1] has suggested this addition in order to augment the content of water soluble vitamin, which, according to the investigations of Osborne and Mendel,[2] is present in yolk in moderate degree. Some years ago, egg yolk was employed on an extensive scale in the Home for Hebrew Infants, and was found a most valuable supplement to milk formulas. Not only did the infants gain steadily in weight, but their general appearance was healthy, the tonicity of their muscles was exceptionally good, and their stools seemed normal. Indeed, the gains in weight were better than those obtained with any other artificial feeding. In the course of one year, some fifty babies were given this food for periods of about six months, and no instance of sensitization or anaphylactic reaction was observed. The only peculiarity was the occasional yellowish discoloration of the skin—carotinemia[3]—which has been described elsewhere in connection with feeding young babies foods rich in carotin. The routine procedure was to prescribe milk of the customary dilution, for example, a mixture of two-thirds milk and water for an infant 3 months of age, with the addition of sugar, and to add the yolk of one raw egg after the completion of the formula. It is surprising how well young infants tolerate this food. Figure 1 illustrates the weight curve of a baby who received egg yolk when 5 weeks old. In the case of infants under 2 months of age, in some instances it has seemed advisable to begin with the addition of half a yolk.

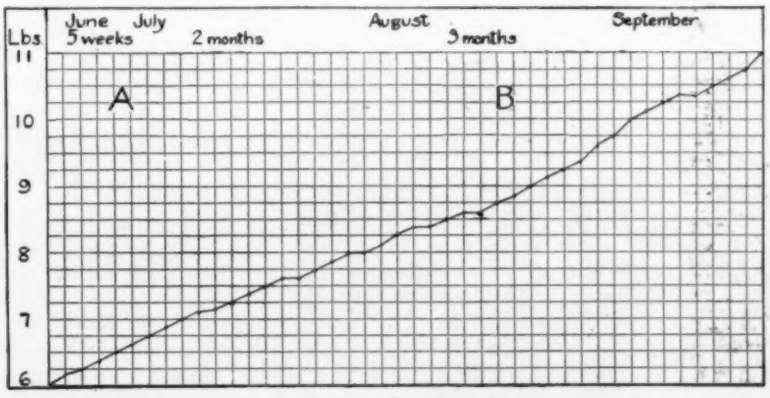

Fig. 1.—Weight curve of infant who received egg yolk from the age of 5 weeks: *A*, milk, 18 ounces; barley water; 18 ounces; cane sugar, ¾ ounce; one egg yolk. *B*, milk, 24 ounces; barley water, 12 ounces; cane sugar, ¾ ounce; one egg yolk.

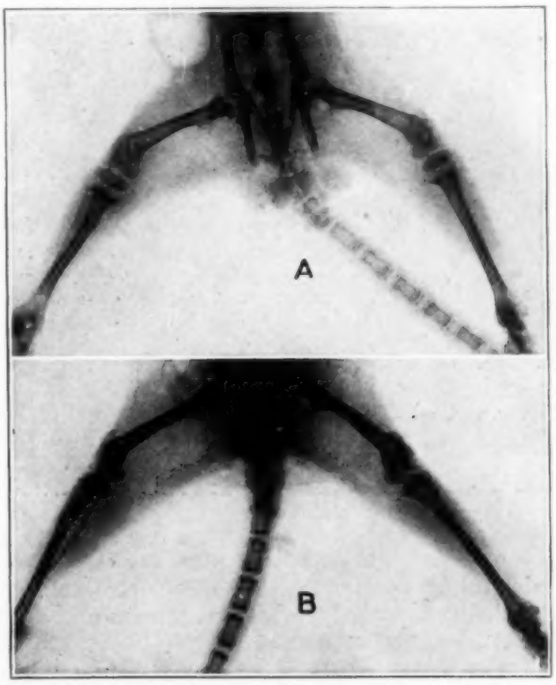

Fig. 2.—Prophylactic teratment: appearance of epiphyses of rats (*a*) on standard rickets-producing diet, and (*b*) on same diet with the daily supplement of 0.25 gm. of yolk of egg.

In view of the high content of fat soluble vitamin in egg yolk, and the close association in nature of this vitamin with the antirachitic factor, as best exemplified in cod liver oil, it appeared worth while to test the potency of the yolk in relation to its prophylactic and curative value in rickets. Mellanby[4] carried out one experiment of this kind, adding two yolks to the dietary of a dog that had developed rickets, and found that this addition exerted a curative effect. In our experiments, rats were employed, the same technic being followed as in the previous experimental work carried out in this laboratory. The Sherman and Pappenheimer low phosphorus diet was used as the basic rickets-producing dietary. To this diet 0.5, 0.3, and 0.25 gm. of egg yolk was added daily. This was given to each animal separately, either by pipet or on a watch glass.

* Read before the Society for Experimental Biology and Medicine, April 18, 1923.

* From the Department of Pathology, Columbia University College of Physicians and Surgeons.

1. De Sanctis, A. G.: Egg Yolk in Infant Feeding, Arch. Pediat. **39**: 104 (Feb.) 1922.
2. Osborne, T. B., and Mendel, L. B.: Eggs as a Source of Vitamin B, J. A. M. A. **80**: 302 (Feb. 3) 1923.
3. Hess, A. F., and Myers, V. C.: Carotinemia: A New Clinical Picture, J. A. M. A. **73**: 1743 (Dec. 6) 1919.
4. Mellanby, E.: Experimental Rickets, Special Report 61, M. Research Council, London, 1921.

It is remarkable with what avidity this addition to the dietary is welcomed. Table 1 shows the result of an experiment of this kind. It will be noted that even 0.25 gm. of yolk (5 drops) was sufficient to protect a rat on a diet which, without this supplement, led to marked rickets. The contrast is well illustrated in the roentgenograms of the epiphyses (Fig. 2); when yolk was fed, normal bones; when it was not fed, the classical picture of rickets.

TABLE 1.—*Prophylactic Treatment of Rats with Egg Yolk*

Rickets-Producing Diet	Daily Amount of Egg Yolk, Gm.	Weight, Gm. At Onset	Weight, Gm. After 28 Days	Roentgenographic Rickets	Pathologic Rickets Gross	Pathologic Rickets Microscopic	Blood Phosphate, Mg. per Cent.
No. 84 (High calcium, low phosphorus)	....	50	44	Marked	R.	R.	2.5
		40	44	Marked	R.	R.	
		50	38	Slight	R.	R.	
No. 84 (High calcium, low phosphorus)	0.25	50	50	Neg.	Neg.	Neg.	4.0
		40	40	Neg.	Neg.	Neg.	
		50	60	Neg.	Neg.	Neg.	
		40	50	Neg.	Neg.	....	
No. 84 (High calcium, low phosphorus)	0.33	30	66	Neg.	Neg.	Neg.	4.5-4.6
		40	60	Neg.	Neg.	Neg.	
		50	58	Neg.	Neg.	....	
		40	58	Neg.	Neg.	....	
No. 84 (High calcium, low phosphorus)	0.5	30	60	Neg.	Neg.	Neg.	5.0-5.0
		40	70	Neg.	Neg.	Neg.	
		40	60	Neg.	Neg.	Neg.	
		40	70	Neg.	Neg.	Neg.	

There are some points in Table 1 to which attention should be called. Especially noteworthy is the marked gain in weight when as little as 0.3 or 0.5 gm. of yolk was added, particularly when compared with the lack of gain evidenced on the standard dietary, as exemplified in the control rats of this series. In this connection it should be emphasized that the bones not merely showed an absence of rachitic lesions, but, according to Dr. Pappenheimer, who carried out the

TABLE 2.—*Curative Treatment of Rats with Egg Yolk*

Rickets-Producing Diet	Daily Amount Egg Yolk (8 Days)	Weights, Gm.	Roentgenographic Rickets	Pathologic Rickets, Gross	Blood Phosphorus, Mg. per Cent.
No. 84 (High calcium, low phosphorus)	.....	50-84	Moderate	Marked	
	.....	40-40	Marked (mod. healing)	Marked	
Dry milk (5%) diet	.....	34-64	Marked	Marked	
		40-50	Marked	Marked	
		50-80	.....	.....	1.5
No. 84 (High calcium, low phosphorus)	0.5 gm.	50-74	Moderate healing	Healing	3.6*
		40-40	Moderate healing	.....	4.0
Dry milk (5%) diet	0.5 gm.	50-74	Slight healing	Healing	5.1
		44-80	Marked healing	Healing	5.5
No. 84 (High calcium, low phosphorus)	1.0 gm.	50-72	Marked healing	Healing	
		40-74	Moderate healing	Healing	
Dry milk (5%) diet	1.0 gm.	40-84	Marked healing	Healing	
		38-68	Complete healing	Healing	

* These analyses were made on the blood of a rat receiving 0.5 gm. pooled with one receiving 1 gm. of egg yolk.

histologic examinations, were particularly strong and well developed. It will be noted also that the rats receiving egg yolk had a higher percentage of blood phosphorus than the control animals, and that this percentage increased in direct ratio to the amount of yolk that had been fed.

The protective effect cannot be ascribed simply to the phosphorus content of the yolk. This content, as determined by the ashing and molybdate titration of a composite sample, was 450 mg. per hundred grams of substance. When 0.25 gm. is fed daily, this addition is equivalent to about 16 mg. of phosphorus per hundred grams of diet, an amount quite insufficient to give this diet protective properties.[5] In our experience, it generally requires 50 or more milligrams additional phosphorus to protect, and less than 35 mg. does not bring it about. These rats were from the stock raised in this laboratory, which, in the course of the last three years, has been used in a large number of similar tests.

Further experiment showed that egg yolk is able not only to protect young rats from rickets, but also to cure them of rickets. Table 2 illustrates a series of tests of this nature. For this purpose, two diets were employed, the low phosphorus flour and salt diet (No. 84), and one in which 5 per cent of dried milk is substituted for an equivalent percentage of flour. These tests proved that 0.5 gm. of yolk suffices to bring about calcification

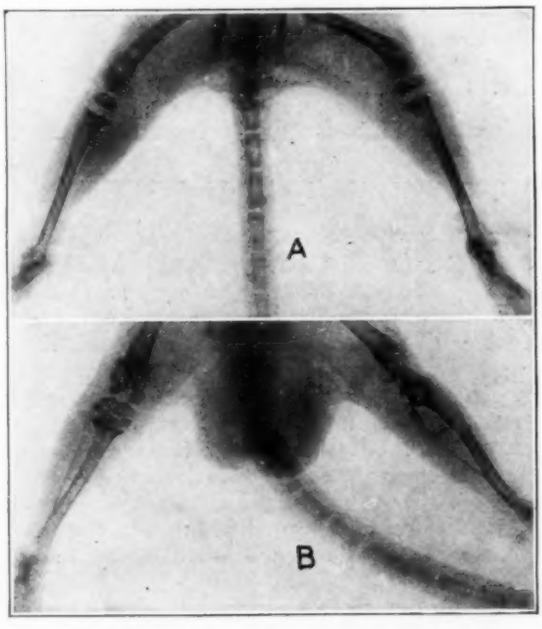

Fig. 3.—Curative treatment: appearance of epiphyses of rats (*a*) on standard rickets-producing diet, and (*b*) on same diet with the supplement of 0.5 gm. of egg yolk for period of eight days.

within a period of eight days (Fig. 3). Probably less will answer the purpose. The rats benefited by this means had a percentage of blood phosphorus considerably higher than those which were not given yolk of egg.

Experiments carried out a year or more ago showed, on the other hand, that white of egg is not merely devoid of antirachitic properties but seems to enhance the rickets-producing quality of a dietary. Table 3 illustrates this point. In this experiment, young rats were fed the low phosphorus diet and irradiated daily with sunlight. It will be noted that they were protected, although incompletely, from rickets—the incompleteness resulting from a deficiency of sunlight during this period. When 10 per cent. of egg albumin was substituted for 10 per cent. of flour in the dietary, the rickets was increased rather than lessened. That this result cannot be ascribed to the withdrawal of the small amount of phosphorus contained in the flour is evident from the third part of the experiment, in which

5. For this calculation, the young rats are estimated to consume about 7 gm. of food daily. It is probable that these rats, in view of their exceptional growth, consumed more than normal, which would render the percentage of added phosphorus still less. (Later experiments have shown that 0.15 gm. of egg yolk daily suffices to protect.)

this withdrawal was compensated for by the addition of an equivalent amount (50 mg.) of potassium phosphate. The rickets in these animals was also of greater degree than in the control rats, and the percentage of blood phosphate, less. It is due probably to this adverse action of the egg albumin that Czerny and others proscribe eggs in the dietary in rickets.

TABLE 3.—*Effect of Addition of Egg White to the Dietary on the Protective Action of Sunlight*

Diet	Weights, (36 Day Period)	Total Irradiation, Hours	Rickets			Blood Phosphorus, Mg. per Cent.
			Roentgenographic	Gross	Microscopic	
No. 84 (High calcium, low phosphorus)	28-40	23.5	Slight	?	Slight	4.4
	30-44	23.5	Very slight	Very slight	Very slight	
	34-50	21.5	None	None	None	
30 days: Diet No. 84 + 10% egg albumin						
No. 84 + 10% egg albumin	34-62	23.5	Slight	Moderate	Moderate	3.47
	34-70	23.5	Slight	Moderate	Moderate	
	36-68	20.5	Moderate	Slight	Slight	
36 days: Diet No. 84 + 10% egg albumin + 50 mg. dipotassium hydrogen phosphate						
No. 84 + 10% egg albumin + 10 mg. P	34-62	23.5	Moderate	Moderate	Moderate	3.42-3.24
	30-68	23.5	Moderate	Moderate	Moderate	
	36-70	23.5	Slight	Slight	Slight	

As is well known, cod liver oil is a specific therapeutic agent for human rickets. Its great drawback lies in the fact that it is poorly borne or not tolerated at all by many infants. It seemed of advantage, therefore, to ascertain whether the same beneficent results could be obtained with yolk of egg in infants as in animals. Our previous experience had shown that the great majority of bottle-fed infants develop rickets during the winter; in this regard there is not only a seasonal but an intraseasonal incidence—the curve rising steadily throughout the winter to its summit at the end of March. Coincident with this wave, there is a seasonal curve of the inorganic phosphate of the blood, which was found to reach its lowest ebb during the month of March.[6] With these experiences in mind, the yolk of one raw egg was added to the regular formulas of each of twelve infants, in an attempt to forestall the occurrence of rickets and the seasonal ebb of the blood phosphate. In most instances, this addition was made in December, when the tendency to rickets

TABLE 4.—*Prophylactic Treatment of Infants with Egg Yolk*

Case	Age, Mos.	Weight, Lbs.	Egg Yolk Begun	Rickets Roentgen-Ray (March)	Rickets Clinical (March)	Feb. and March	
						Phosphorus	Calcium
1	12	19½	12/14/22	Negative	Negative	3.8	11.0
2	10	18	1/16/23	Negative	Negative	3.7	12.4
3	14	20¼	1/ 8/23	Negative	Negative	4.6	10.8
4	11	18	12/24/22	Negative	Negative	3.9	12.0
5	6½	16½	12/22/22	Negative	Negative	4.5	....
6	6½	12¼	12/14/22	Negative	Negative	4.5	11.2
7	12½	16¾	12/14/22	Negative	Negative	4.1	11.8
8	10	17	12/14/22	Negative	Negative	4.3	12.0
9	12	17¼	12/14/22	Negative	Negative	4.0	12.0
10	13½	18¾	12/14/22	Negative	Negative	4.0	....
11	10	15¾	1/ 8/23	Negative	Negative	4.3	....
12	13	25	12/20/23	Negative	Negative	4.0	11.4

becomes acute. Table 4 shows the result of this protective therapy. By this simple supplement to the diet, all the infants were protected from rickets, as judged by clinical, roentgenologic and chemical criteria. It will be noted that the percentage of inorganic phosphate in the blood, instead of falling to 3.6 mg., the ebb observed last March, was maintained at 4 mg. or more, a level encountered during the summer months.

6. Hess, A. F., and Lundagen, M. A.: A Seasonal Tide of Blood Phosphate in Infants, J. A. M. A. **79**: 2210 (Dec. 30) 1922.

The calcium content of the serum also was unusually high. These results require but little comment. It is evident that yolk of egg possesses considerable protective value in rickets.[7] It should also be remembered that it is exceptionally rich in iron.

The curative results were not so striking, as might be expected, for much larger quantities of the antirachitic factor are required to bring about a cure. When cod liver oil is given to the amount of one teaspoonful three times a day, healing frequently cannot be observed by roentgenogram for several months; in a series of cases the average period was two and one-half months and still longer in some cases during the winter months. In the cases in which egg yolk was employed, calcification was observed in one instance after a month, and in another after one and a half months. In other cases it seemed decidedly less potent than cod liver oil, nor did the percentage of blood phosphate respond so promptly. This effect will be found to vary with the severity of the case, the adequacy of the diet, and the amount of sunlight to which the infant is exposed.

CONCLUSION

Egg yolk possesses marked antirachitic properties for animals and for infants. It has proved itself of great value in protecting infants from rickets during the season when the incidence is greatest, and, with this in view, can be recommended as a supplement to the dietary comparable to orange juice in the protection against infantile scurvy. It has also curative value, but less than cod liver oil, and therefore should not be relied on for cure except when the oil is not well borne.

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THE TREATMENT OF VOMITING

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Vomiting, one of our protective reflexes, not infrequently requires treatment because of uselessness, excess, or a tendency to self-perpetuation.

USEFUL VOMITING

Is there irritating material in the stomach? should be the first question in the treatment of vomiting. If there is, as in a case of drug or food poisoning, emesis should be encouraged by copious drinking of lukewarm water, unless a stomach tube is available. The use of this is preferable, as with it one can cleanse the stomach much more thoroughly. When offending food is vomited, the emesis requires no direct treatment. All that is necessary is to give the stomach rest for a few hours. We must, however, beware of falling into the facile error, so commonly committed by the laity, of incriminating whatever food has just previously been eaten, when, in reality, the vomiting frequently is symptomatic of some disease like cholelithiasis or appendicitis. Earmarks of the presence of one of the latter conditions are the irregularity of its occurrence, and the fact that a certain food at times disagrees and at other times is well digested. Such patients often go on eliminating food after food from their diet because of

7. It is impossible to compare its value with cod liver oil. The prophylactic dose of cod liver oil is not known. Probably the amounts customarily used are unnecessarily large, and 10 drops three times a day will suffice to afford protection. A definite amount cannot, however, be arbitrarily fixed, as this will vary with the nature of the diet which the infant is and has been receiving.

supposed idiosyncrasy, until they have reduced the dietary to mush and milk, which also disagrees at times. Food idiosyncrasy is usually constant and limited to a few definite articles of diet. Spoiled food generally affects all those who partake of it.

The lusty baby often overdistends its little stomach by taking more milk than it can hold, and then it regurgitates the excess. Better for it to do this than to suffer from indigestion due to excessive feeding. Mothers consult physicians about this physiologic vomiting. All that is required to prevent its occurrence is nursing at a slower rate—by the mother's pinching the nipple of the breast with her fingers—or by nursing for a shorter time, or both. When the baby is fed artificially, the fault lies generally with the holes in the nipple being too large. From the nipple of the inverted nursing bottle, the drops should come but slowly. Fast dropping of the milk means that the holes are too big. We must be careful to distinguish this simple form of infantile vomiting, which is of no more danger than a sneeze, from the serious vomiting of hypertrophic pyloric stenosis, which presents the combination of excessive vomiting, constipation and wasting. The vomiting in these cases is very forcible, most of the milk taken being violently rejected with but little alteration. The presence of a small tumor in the epigastrium, visible gastric peristalsis, and the results of roentgenray examination would make the diagnosis complete. The antispasmodic treatment suitable for this condition will be discussed later.

The vomiting so commonly occurring at the onset of febrile diseases, such as scarlet fever or pneumonia, may have a beneficial tendency. At any rate, it stops in the natural course of events and needs no special treatment. A person suddenly taken ill with fever, who has a full meal in the stomach, is better off getting rid of it by emesis than having it pass all the way through the alimentary tract and adding intestinal intoxication to the poisoning of the disease. Our forefathers in medicine regularly induced emesis at the beginning of treatment of severe diseases, and probably not always injudiciously. If the vomiting continues with fever and there is abdominal pain, tenderness, and rigidity from the onset, we should suspect the presence of an acute surgical condition of the abdomen, e. g., of appendicitis. Continuance of painless vomiting in a feverish child should lead to inquiry for meningitis, uremia or acidosis. Abdominal pain and tenderness may develop from muscular strain in any patient vomiting excessively, but this occurs only after the vomiting has lasted several days and then there is a feeling of soreness, especially at the points of muscular insertions,

NEGLIGIBLE VOMITING

In quite a number of cases, emesis is merely accidental or incidental, bearing no relation to the condition of the stomach or to the functional capacity of the alimentary tract. In such conditions, it is wise, unless the vomiting is excessive, to ignore it as far as the therapeutic program is concerned. The application of the standard treatment for excessive vomiting, a gastric rest cure, would be a mistake in these cases, because gastric rest means starvation, and this brings with it acidosis and increased irritability of the vomiting center in the medulla. It is in this manner that vomiting has a self-perpetuating tendency. Children, diabetic patients, and probably also pregnant women, are especially prone to the development of acidosis, and should most especially be protected against it.

It will readily be understood what a mistake it would be to stop feeding a child that suffered from whooping cough or some other form of emetic cough. Since the stomach here is sinned against and not sinning, abstention from food would not only do no good but might harm the patient by lessening resistance and possibly also by increasing the tendency to vomit by the production of acidosis. In the adult, emetic cough is much less common than in the child and requires more serious consideration, chiefly because it is occasionally due to tuberculosis. Here, again, it will be seen what a mistake it would be to restrict the patient's diet because of it.

No less irrational would be diet restriction in those cases of emetic cough occurring in the bronchitis and even the pharyngitis of the neurasthenic patient. Here, liberal feeding and the appropriate treatment of the pharyngitis and bronchitis, aided possibly by a course of bromid to lessen reflex excitability, will give the desired result. The morning vomiting of the drunkard, being due to the night's accumulation of mucus in the pharynx and stomach, which the patient gets rid of by the emesis, might possibly be even considered a useful form of vomiting. At any rate, it is not to be treated by withholding food, but rather by the diet suitable to the form of gastritis present, by treatment of the pharyngitis, and by protecting the patient against further injury from the poison.

The vomiting of seasickness does not require abstention from food and drink. The patient should eat sparingly of simple foods, such as gruel, dry toast, plain biscuit or chicken; he should avoid distention of the stomach by the consumption of liquids and fruits; and, as soon as a feeling of nausea develops, at once go to his berth and keep his head down. Complete rest, with the head low, is one of the safest and surest preventives not only for this but also for many other forms of emesis. Should the patient have to keep up and about, or not be relieved by the recumbent posture, atropin treatment, such as advocated by Girard,[1] may be tried. It consists of the hypodermic injection of 0.5 mg. of atropin sulphate, possibly combined with 1 mg. of strychnin sulphate, repeated twice at hourly intervals if required, unless incipient dryness of the throat and disturbance of vision warn one that atropinism has been reached. If this fails, and it sometimes does, some of the means of treatment for obstinate emesis will have to be employed.

The ordinary vomiting of pregnancy, as distinguished from hyperemesis gravidarum, is a similar condition. One should encourage the patient to go on eating bravely, even if the food is vomited shortly after, because some of it will stay down and sustain the body, surely more than if no food were taken. It is well not to let the patient raise her head from the pillow in the morning without previously putting something into her stomach, such as a cup of hot coffee. It has been suggested that the special prominence of the vomiting of pregnancy in the morning is due to the development of a slight degree of acidosis from food abstinence during the night. This would explain the reason for the good

1. Girard, A. C.: Atropin and Strychnin Combined. A Specific for Seasickness, J. A. M. A. 46: 1925 (June 23) 1906.

results so frequently obtained from the simple measure indicated.

EXCESSIVE VOMITING

Like many other blind reflexes, emesis is frequently useless and excessive, as when it is maintained by abnormal irritability of the vomiting center or by a peripheral irritation that it cannot remove; and it threatens by increase of the excitability of the vomiting center from starvation acidosis to establish a vicious circle.

When the stomach has become inflamed, vomiting continues because of the gastritis, even though the stomach is empty. Irritation anywhere else in the vast domain of the pneumogastric nerve will produce the same result. Excitation of the glossopharyngeal nerve, especially its pharyngeal expansion, and of some of the other cranial nerves, as well as stimuli arising within the central nervous system, varying from disgust and hysteria to excessive intracranial pressure and locomotor ataxia, are all capable of producing and maintaining emesis. It is a clinical fact that, excepting in the young, vomiting is more commonly due to extragastric than to gastric causes; in other words, it is more frequently useless than useful.

From the considerations given it will be obvious that there are two fundamentally different modes of attack applicable to the treatment of any case of vomiting: to remove the irritation and to lessen the irritability; and either may be peripheral or centric. The various modes of attack are, on the whole, in inverse proportion of importance to one another in accordance with the underlying cause; but, in many cases of obstinate vomiting, they may usefully reinforce one another.

REMOVAL OF PERIPHERAL IRRITATION

Gastric rest is the single most important means of lessening the stream of afferent stimuli affecting the vomiting center in almost any variety of excessive vomiting. Such gastric rest treatment practiced *secundum artem* should include not only the withholding of all food and drink, but also keeping the mouth and lips moist, as well as parenteral administration of fluid, antiketogenic regimen, and complete rest in the horizontal position. In many forms of vomiting, emesis does not take place as long as the patient keeps his stomach empty and does not raise his head. Teaspoonful doses of very hot or very cold water or of seltzer water may be given—but not oftener than every fifteen minutes—to keep the mouth moist; and petrolatum should be applied to the lips to keep them from chapping or cracking. Medicine must not be permitted to interfere with the gastric rest. Local antiemetic medication is often a delusion and a snare. When a medicine given to stop vomiting is promptly rejected, one cannot blame the patient if he loses confidence in its prescriber. It is best, therefore, not to risk this occurrence, especially at the beginning of treatment. The administration of cathartics must likewise not interfere with the gastric rest. If the patient's bowels can move, they will whether a cathartic is given or not; if they cannot move by reason of intestinal obstruction or other surgical condition of the abdomen, the administration of cathartics is a serious error. To relieve thirst and to antagonize starvation acidosis, which in turn tends to maintain emesis, retention enemas of sodium bicarbonate solution (2 per cent.), to which glucose (5 per cent.) can be added, may be employed. Hypotonic solution is preferred, as it prevents thirst better than isotonic solution. The principle underlying the determination of the quantity of the solution to be used by rectal administration is to inject the most that can be retained. To arrive at this amount, it is best to commence with rather small quantities, say 100 or 200 c.c., given high by catheter or rectal tube and slowly, the solution being at body temperature. If these quantities are well retained, the amount injected is gradually increased. The injections may be repeated every two to four hours, as long as small amounts are given; and, as the quantity is increased, the intervals may be increased also to six or eight hours. This is preferable to the rectal drip, which is generally very annoying to the patient. In infants, from 25 to 50 c.c. of the solution may be injected every two hours. A catheter, with the glass barrel of a small piston syringe serving as a funnel, is probably the best and generally most easily obtainable means of giving these retention enemas; though, for infants, a soft rubber so-called ear syringe, manipulated so as to secure slow injection, has served so well that even inexperienced mothers have little difficulty in carrying out the treatment. Once daily, an evacuant enema of the same solution is given, administered with the same technic, excepting that enough is injected to excite expulsion of the colonic contents.

Every now and then, cases are encountered in which the mere giving of an enema excites emesis. We must be on the lookout for such cases, and promptly stop the enemas should they seem to maintain vomiting. In such cases, as well as in neglected cases of obstinate emesis, when dehydration of the system has occurred to a considerable extent, duodenal administration, as described below, or hypodermoclysis should be resorted to. In bad cases of this kind, intravenous injection of glucose solution, and in children its intraperitoneal administration, may be of lifesaving importance.

Obviously, an antidote is indicated when the presence of a chemical irritant can be proved, and an antidote is available, as in acid or alkali poisoning, or when the vomitus shows the presence of hyperchlorhydria, as indicated by dark blue coloration of Congo paper. The best antacids in cases of vomiting are chalk or magnesium oxid, selection between the two being made according to whether we desire the constipating tendency of the calcium or the laxative action of the magnesium. Of course, when these are not at hand and sodium bicarbonate is available, this might be administered as an antacid, though it is more likely to be rejected by vomiting.

Lavage is the supreme remedy for removing irritant material from the stomach. It is absolutely indicated in poisoning unless of deep, corrosive variety. Fecal vomiting presents another absolute indication for lavage. It is nothing less than inhuman to let a patient bring up such revolting material through the mouth, when it may be so much more mercifully removed by washing the stomach. This, of course, does not cure the patient under these circumstances of intestinal obstruction; but it gives temporary relief and is an excellent method in preparing the patient for operation.

Lavage is frequently the best measure to check bile vomiting, because we have to deal here with a vicious

circle. Each time the patient vomits, the forcible compression of the gallbladder causes ejection of bile, which then is forced into the stomach, there precipitating recurrence of the act. Washing of the stomach until the fluid returns clear may be the very thing required to put an end to this chain of events. When motor insufficiency of the stomach, with or without pyloric stenosis, causes food retention for a sufficient length of time to result in the formation of irritant material, which damages the gastric mucous membrane before it is eliminated by vomiting, lavage is again a method of breaking in on a vicious circle and should be performed regularly once or twice daily at a time when it is certain that the food still remaining in the stomach will do more harm than good. This time is perhaps, in most cases, just before going to bed.

Surgical removal of the peripheral irritation should be undertaken as soon as the diagnosis of the necessity of surgical intervention has been made. Every hour of delay increases the danger to the patient, not only by way of increase in the local pathologic condition or the accession of surgical complications, but also because the dehydration and the starvation with its accompanying acidosis make the patient a poorer surgical risk the longer the condition lasts. Therefore, when we suspect a surgical condition of the abdomen, no time should be wasted in futile attempts to check the vomiting by medicinal means. On the other hand, the absolute gastric rest with or without lavage, as indicated, constitutes the best possible preparation of the patient for operation. So important is prompt diagnosis and surgical treatment, that the mere suspicion of the possibility of necessity for operation should make us urge hospitalization, the means for careful study and prompt treatment of the case being so much better in the hospital than in the home. In such cases, it is not only merciful but true to tell the patient that one advises removal to a hospital for careful study of the case, and that operation will, of course, only be resorted to if there is no safer way of relief. We must be just as careful of avoiding the appearance of rushing a patient to an operation as we must of delaying an operation too long. Surgical consultation should not be deferred in such cases; but the surgeon to be chosen should be one who does not suffer from "furor operandi."

Of course, even at the first visit, the patient has been given a careful physical examination with particular attention to the abdomen, and a conscientious attempt has been made to arrive at a diagnosis. Nevertheless, there are occasions when it is necessary to place the patient on the treatment just outlined, a diagnosis being impossible without further examination. We should never neglect to obtain at the very first visit a specimen of the urine for examination. The importance of this will be appreciated from the fact that in nephritis and nephrolithiasis, as well as in diabetes, it will put us far along the way toward the correct diagnosis and treatment. It is probably less well known that, in the differential diagnosis between appendicitis and the periodic acidemic vomiting of children, which sometimes—remarkable as it may seem—presents difficulty, the early, pronounced and constant presence of ketone bodies in the urine would point to the vomiting of acidosis, while its absence at the first examination would exclude this condition. Later on, the urinary findings of acidosis may appear in any case of excessive emesis.

It is unfortunate that the laity nearly always promptly throws away the vomitus and bowel evacuations. It is necessary, therefore, to lay down the specific rule that, should the patient vomit, the evacuation be saved, and that a specimen of the bowel movement likewise be kept for examination.

At the physician's next visit, after twelve or twenty-four hours of such treatment, one of two conditions may be found: either the patient has vomited or he has not. In either case, it is necessary to modify the treatment. If the patient has vomited, continuance of the gastric rest treatment is indicated, with the additional effort to be discussed under the treatment of obstinate emesis. If the patient has not vomited, then the gastric rest may be gradually relaxed. In the majority of cases, the amount of water may be increased to a tablespoonful every half hour, and this may be alternated with a teaspoonful each of milk and seltzer water every half hour. For children who, as a rule, dislike seltzer water, barley water or lime mater may be substituted for the dilution of the milk. If the patient has constipation, and no contraindication to catharsis exists, a few doses of magnesia magma may be substituted for the seltzer water or lime water. After eight or twelve hours, if no emesis has occurred, a tablespoonful each of milk and seltzer water or other fluid may be allowed; and, a few hours later, conditions continuing favorable, a wineglassful of the mixture may be given every hour.

In favorable cases, on the third day, the patient should be well on the road to recovery. The nausea having disappeared, the patient may now be placed on the customary liquid diet of hospitals, and the rectal administration of fluid discontinued as soon as it is evident that the patient retains a sufficient amount of fluid. If, however, nausea still persists, it is better to avoid distending the stomach with fluid. Small quantities of soft food, such as farina or oatmeal gruel, may be given every two hours, and restricted amounts of fluid given alternately every two hours.

REMOVAL OF CENTRIC IRRITATION

In proportion to the degree in which acidosis dominates the causation of vomiting, the administration of carbohydrates is of importance. We now know that oxidation in the body in the absence of a sufficient amount of carbohydrate yields acid products such as diacetic and oxybutyric acids, which in turn increase the irritation of the medullary centers to such an extent as to produce and maintain vomiting even without the cooperation of any other cause. We also know that, in this kind of vomiting, carbohydrate is the chief remedy. A special problem of this kind occurs in the treatment of diabetes, in which the lately popular starvation treatment occasionally precipitates acidemic vomiting, for which the prompt recourse to carbohydrate feeding, coupled with the administration of insulin and given intravenously in great emergency, is specifically antagonistic.

Alkali may also be resorted to in this condition, though it is less likely to be successful, as it does not strike at the cause of the disorder, and practically impossible quantities may be required to neutralize the acid continually formed in metabolism. Oral administration of alkalis in the quantities required is impossible because of the emesis. Giving the solution by

rectum may well be carried on in the routine treatment of emesis, as previously directed, but its value in severe cases of acidosis is limited by the rather poor retentive and absorptive quantities of this organ. Hypodermic administration is out of the question, because of the danger of the production of necrosis. Intravenous infusion of from 1,000 to 1,500 c.c. of a 4 per cent. sodium bicarbonate solution may be required by a serious emergency. It is too heroic a procedure to be repeated sufficiently often to do more than tide the patient over a grave crisis, and intensive repetition of the treatment is liable to cause edema. It is possible that duodenal tube administration of alkali (as described below) may be found to be the most efficient method.

Certain mechanical measures may be instrumental in lessening centric excitability. Thus, lumbar puncture, and the lowering of pressure produced thereby, may be of value in those cases of cerebral vomiting associated with excessive subdural pressure. This cerebral vomiting is characterized by the absence of nausea so common in vomiting, due to abnormal states of the gastro-intestinal tract and of other abdominal viscera. It may also be accompanied by a normal tongue and absence of other evidences of disordered digestive function. The triad of vomiting of this type, headache and ocular changes should arouse suspicion of the presence of organic cerebral disease, such as tumor, abscess, meningitis or sinus thrombosis; and the surgery appropriate for some of these conditions should be instituted as promptly as possible.

OBSTINATE VOMITING

Thus far, antiemetic drug treatment has not been brought into requisition, chiefly because it is generally useless, unless the measures previously discussed are also employed; and, when these measures are instituted, other antiemetic treatment is not required in a large number of instances. When, however, vomiting proves obstinate, whether because of essential incurability of the disease, or of obscurity of diagnosis, or because medical treatment should be employed only as a last resort, as induction of labor in hyperemesis gravidarum, then definite results may be secured by the skilful use of antiemetics that lessen either peripheral or centric irritability. For the simple reason that they do not require peroral administration and a retentive stomach, the centric antiemetics are more reliable in action and, on the whole, more important than the local or gastric antiemetics.

LESSENING OF CENTRIC IRRITABILITY

Among the sedatives that may be useful in the treatment of vomiting, bromids, though feeble in action, are the first to be considered because they have less undesirable side effects than other more powerful agents. Being endowed with local irritant action and being capable of producing emesis, bromid should, of course, in the treatment of this condition, not be given by stomach, but by means of retention enemas. A dose of 1, 2 or 4 gm. of sodium bromid may be added to the previously described retention enemas. It is best not to exceed a concentration of 1 per cent.

When the nervous element is a prominent feature in the causation of vomiting, as in the crises of locomotor ataxia or in some cases of hyperemesis gravidarum, it is well to make the effect more certain by reinforcing the bromid with chloral. This should be given in full dose so that a reliable effect can be obtained from the first. Success has an important psychologic effect in giving a patient confidence in his physician as well as in himself. This prescription might be employed:

	Gm. or C.c.	
℞ Chloral hydrate	4	ʒ i
Sodium bromid	8	ʒ ij
Water ....?....to make	60	fl ʒ ij

M. Label: Tablespoonful in starch water to be given as enema.

When the use of chloral is objectionable by reason of circulatory depression, the rectal administration of 0.5 gm. of barbital sodium may be resorted to instead. It is generally advisable to continue such medication every four or eight hours for several days; and, when the desired effect has been obtained, to discontinue by a gradual reduction of the dosage.

In serious cases, in which the other remedies fail, the most efficient agent, provided no idiosyncrasy exists against its use, is morphin given subcutaneously in doses of 0.01 gm. every hour or two for, at most, three doses, or else in the form of suppositories. Morphin is required chiefly in those cases of emesis accompanied by pain, provided we do not deal with an acute, surgical condition of the abdomen, in which the administration of morphin is strongly contraindicated. While in cholelithiasis and nephrolithiasis the employment of morphin, preferably associated with atropin, is of the greatest possible help in relieving the agony of the attack, the same action in such conditions as acute appendicitis or intestinal obstruction might so obscure the symptoms as to delay the necessary surgical procedure, thus lessening the patient's chances of recovery. It is a curious fact that the action of the very drug most potent in checking vomiting is followed by vomiting as a common after-effect. It is well, therefore, to make provision for this action in all cases in which morphin is administered, and most especially when it is used in the treatment of emesis, by directing that when the patient awakes from sleep, he should not be permitted to raise the head for several hours. Meanwhile, he should be given nourishment, including preferably the use of coffee. When the tendency to nausea asserts itself strongly, it is best to continue the administration of morphin with atropin in progressively descending dosage, using perhaps every four hours one half of each previous dose.

Psychotherapy is of greater importance in the treatment of vomiting than is generally realized. When we recollect the fact that disgust may translate itself into nausea and even vomiting, that seeing another person vomit nauseates a great many persons and might even cause them to vomit, it will perhaps be easier to understand the importance of the psychic element in the treatment of emesis. It is well known, for instance, that seasickness may be voluntarily inhibited to a considerable degree by keeping the mind occupied with other things than one's own sensations. One of the reasons why staying on deck as much as possible somewhat protects against mal de mer is that the very odor of the ship's cabin is frequently nauseating and not calculated to help in self control. The mental state has probably also a great deal to do with excessive vomiting in some cases of pregnancy, as when the woman is pregnant with an unwelcome child; and this without necessary connection with voluntary reinforcement of the condition, as might occur if the patient knows that

abortion is the final remedy for the uncontrollable vomiting of pregnancy. It is well, therefore, in all cases of obstinate emesis not only to suggest to the patient to resist, all he can, the desire to vomit, but also to protect the patient from unfavorable suggestions. In some cases, the seclusion insisted on in connection with the Weir Mitchell rest cure is of importance in protecting the patient against the unfavorable suggestions emanating from anxious questions and tactless remarks by solicitous relatives.

Maintaining nutrition might as well be discussed under this heading, because a person with a starved brain will be least able to exercise control, and because malnutrition of the central nervous system increases its irritability. Furthermore, in any case of vomiting uncontrolled for a great length of time, it becomes a matter of life and death whether nutrition can be maintained or not. Stomach tube feeding is especially likely to be of help in cases of otherwise uncontrollable vomiting in which the hysterical element is prominent. That food, such as predigested milk, is sometimes retained when given by stomach tube, even though the stomach has previously been absolutely nonretentive, is a clinical fact. Probably the very disagreeableness of this mode of feeding may have a wholesome psychic influence in these cases, especially if the patient knows that, should the food come up, down goes the stomach tube again. As a final resort, we have duodenal alimentation. Thus, Einhorn [2] cites three examples of successful feeding of patients by means of the duodenal tube, when they were unable to take nourishment on account of vomiting. None of the patients thus fed lost weight appreciably. Milk and eggs were the main food material forced through the tube.

An interesting case of obstinate vomiting with semicoma and muscular twitchings from reflex anuria has been reported by McCarthy, Killian and Chace.[3] All the customary remedial measures, such as medication by mouth, rectal drips, colonic irrigations, hypodermoclyses, and bloodletting, with intravenous infusion of glucose solution and sodium bicarbonate, were exhausted, and the patient still continued in a bad condition. A spectacular result was secured from the use of the duodenal tube and the introduction, by means of it, of 5 per cent. glucose solution, 2 per cent. sodium bicarbonate, and, for catharsis, sodium sulphate. Feedings were also given through the duodenal tube, consisting of peptonized milk, sodium bicarbonate, cream, water and glucose solution, about 1,000 calories every twenty-four hours. The vomiting ceased, the urine output increased tremendously, and so great was the effect of the sodium bicarbonate in causing a rise in the carbon dioxid combining power of the blood that it became necessary to discontinue the alkali. Four or five days later, a lavage of the entire intestinal tract by duodenal tube with from 2 to 4 liters of tap water, three times a day, was undertaken, and a pronounced reduction in the blood retention of urea nitrogen and creatinin was secured.

LESSENING OF PERIPHERAL IRRITATION

To the extent to which excessive gastric irritability exists, local measures for its control may be of advantage. First and foremost among these are protectants, such as the insoluble salts of bismuth. Among them, bismuth subcarbonate probably deserves preference to the subnitrate, because of the possibility of nitrite poisoning occurring from administration of the latter. It is, of course, illogical to administer this or any other antiemetic in tablet or capsule form. Even the voicing of this proposition might seem unnecessary, had it not happened that a hospital pharmacist dispensed bismuth subnitrate tablets, which were promptly vomited, while the powder suspended in a little water was retained.

Local anesthetics may be of help, especially when a focus of local irritation, such as cancer or ulcer, is responsible for the vomiting. Of these, benzocain (anesthesin) is possibly the agent of choice, as it may be safely given in doses as high as 0.50 gm., though a dose of one-tenth this amount may suffice to exert a sufficient degree of anesthetic action. As a preventive of postanesthesial vomiting, the administration of chlorbutanol (chloretone) in doses of from 0.5 to 1 gm. as a preliminary to the giving of a general anesthetic may be useful, as it not only lessens local irritability but also is of value in the production of general anesthesia. Procain or cocain hydrochlorid in doses of 0.01 gm. may also be given. It may possibly be combined with menthol, as in this prescription, recommended in the treatment of seasickness:

		Gm. or C.c.	
℞	Menthol	10	gr. iss
	Cocain hydrochlorid	20	gr. iii
	Alcohol 90		fl ʒ iii
	Saccharin	09	gr. iss

M. Label: Teaspoonful in water every half hour until relieved.

Tincture of aconite, in minim doses repeated every hour, may be thought of for its depressant action on nerve endings in those cases in which its action as a circulation depressant might possibly be of value by lowering intracranial tension.

Such agents as phenol (carbolic acid) and creosote in small doses might be considered the local anesthetic of choice in cases of vomiting in which excessively prolonged gastric retention is responsible for fermentation. Such cases would, however, be managed more efficiently by means of lavage.

How irritants given by stomach check vomiting is one of the puzzles to be solved. It is a fact that 15 drops of tincture of capsicum given in a cupful of hot milk will often be retained by a patient suffering from alcoholic gastritis when other things, even liquor, are being vomited. Since an alcoholic patient under these conditions is a candidate for delirium tremens, which is in part, at least, due to starvation, this trick of treatment is worthy of recognition. The time honored recommendation of drop doses of tincture of ipecac or of iodin is probably based on psychic action. They have the reputation of succeeding when everything else has failed. It may be that such remedies do so because they happen to be given at a time when the condition under treatment has come to its natural end.

Counterirritation over the epigastrium is another time honored remedy supposed to succeed when other measures fail. The simplest way to obtain such effect would be the application of a mustard plaster to the epigastrium for from fifteen to thirty minutes. Heat applied to the epigastrium might help in retaining a meal otherwise vomited. Winternitz's supreme "stomach remedy" consists of a heating coil over the epigastrium enclosed in a trunk compress applied cold,

2. Einhorn, Max: Duodenal Alimentation, M. Rec., July 16, 1910.
3. McCarthy, J. F.; Killian, J. A., and Chace, A. F.: Reflex Anuria, J. A. M. A. **80**: 1043 (Oct. 14) 1923.

covered with flannel and permitted to remain until it is thoroughly warmed up. The recumbent posture forced on the patient by this treatment is at least one of the reasons for its success.

An antispasmodic regimen should not be overlooked in cases of obstinate emesis. Attention has already been called to its value in the treatment of seasickness, and also to its use in connection with morphin in the treatment of gallstone or renal colic. Obviously, the greater the importance of spasm in the emesis, the more important is atropin therapy. Thus, in pylorospasm, it is the most important means of medicinal treatment. As this condition occurs chiefly in children, it must be borne in mind that these bear much larger doses of atropin than that arrived at by applying the classical dose rules. Enough should be given either to control the symptoms or to produce undesirable side-effects, such as marked flushing of the skin or dryness of the mouth. As aqueous solutions rapidly deteriorate, it is best to dissolve a 1 mg. tablet of atropin sulphate in 1 c.c. of water and to start with 1 drop of this solution before each feeding. In the milder cases, the dose may be given in the bottle of artificially fed infants, or, if the child is breast fed, in a teaspoonful of water before nursing. In severe cases, the drug should be administered hypodermically. Should 1 drop fail to relieve, the dose is increased progressively to 2, 3 or more drops. Haas [4] reports his experience with more than forty cases of pylorospasm, in nearly all of which this treatment was successful. The largest dose employed was a little less than 1 mg. at each feeding, or 8 mg. in the twenty-four hours. Such treatment may be required for only a few weeks or for the greater part of the first year. When constipation with rectal tenesmus occurs during the course of this treatment, the omission of a few doses of atropin usually relieves this.

An interesting controversy regarding the effect of atropin on gastric motility, as observed roentgenoscopically, has arisen between Lasch [5] and Oetvös,[6] due, as will be noted, to difference in dosage occasioned by difference in mode of administration. Lasch gives from 1 to 1.5 mg. of atropin intravenously, while the patient is being observed with the fluoroscope, and reports—after a transient increase in peristaltic action in some cases—the regular and definite lessening of tone and of the peristalsis in cases of hypertonus and hyperperistalsis, while normal or deficient tonus or peristalsis is not influenced. Oetvös, on the other hand, finds that 1 mg. of atropin solution injected subcutaneously causes pylorospasm in patients with deep ulcer in the vicinity of the pylorus so regularly that he proposes this as a test for deep pyloric or duodenal ulcer, as such an effect is not obtained when the ganglion cells in Auerbach's plexus are not affected by deeply extending disease. These studies obviously point to the practical fact that we must not hesitate to push the dose to the physiologic limit, as a large dose may succeed when a small dose fails; and they also prepare us to understand why atropin may fail as an antispasmodic in certain cases of peptic ulcer.

4. Haas, S. V.: Congenital Hypertrophic Pyloric Stenosis and Its Treatment by Atropin, J. A. M. A. **79**: 1314 (Oct. 14) 1922.
5. Lasch, C. H.: Röntgenologische Untersuchungen über den Einfluss des Atropins auf die Magenmotilität, Klin. Wchnschr. **1**: 840 (April 22) 1922.
6. Oetvös, Erwin: Röntgenologische Untersuchungen über den Einfluss des Atropins auf die Magenmotilität, Klin. Wchnschr. **1**: 362 (Feb. 18) 1922; **1**: 1209 (June 10) 1922.

THE TREATMENT OF CONGENITAL DACRYOCYSTITIS *

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The term "congenital dacryocystitis" is a misnomer. The condition develops after birth, and not before, and is not a true inflammation of the sac wall, but an infection of the retained excretions from the conjunctival sac. The condition that predisposes to this postnatal infection, however, is congenital in the sense that there has been a delay in Nature's process of canalization of the lacrimal passageways. This is manifest in at least 95 per cent. of all cases by delayed opening into the inferior nasal wall.

We are indebted to Born, Legal, Kolliker, Ewetzky, Schaeffer and others for our knowledge concerning the embryologic development of the nasolacrimal passageways; but to Schaeffer, perhaps, belongs the credit of a more thorough study of the subject in the human embryo, commencing when the initial cells are laid down and continuing the study until it is complete at the end of gestation. From his investigations, we learn that this development begins at about the end of the fifth week, in the naso-optic groove, by a process of proliferation, and continues until the cells are finally submerged in the mesenchymal tissues by a gradual closure and obliteration of the groove or fissure. These epidermal cells now become a detached cord, having no communication with the surface at either extremity. By a process of "budding," the ends of this cord find their way to the surface epithelium again, the superior end forming the dome of the sac and canaliculi, the lower end terminating in the inferior nasal meatus. As this development progresses, there is, at the same time, a rearrangement of the cells so that distinct walls are formed; the lumen of the passageways become manifest, and the innermost cells become necrotic and ready for expulsion as soon as the passage is opened, which usually occurs at, or before, birth. The nasal opening is the last to form; in a great many instances it is impervious at birth, but canalization may continue until the nasal mucosa is reached, or until the retained secretions, with the aid of the muscular action of the lids, cause the thin partition wall to rupture.

It is this delayed opening of the nasal end of the duct with which we are chiefly concerned in the treatment of congenital dacryocystitis. It is a well known fact that a great many cases of this nature recover spontaneously. Cases in which there has been a persistent epiphora for several weeks or months after birth, followed by cessation, are undoubtedly due to Nature's completion of the process of canalization.

But the cases with which the ophthalmic surgeon has to contend are those in which no such favorable termination is achieved. Relief is sought for a purulent discharge from the eye, which was preceded by a persistent overflow of tears. There is usually no history of pain, redness or swelling, either of the lids or of the conjunctiva. The sac wall may appear distended when the purulent fluid has been allowed to accumulate, but there is no real inflammatory infiltration unless the infection has persisted for a long time. The lacrimal sac has simply become a culture tube, and the fluid mixed with retained necrotic débris, a favorable culture

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medium. As soon as proper drainage is established, recovery is prompt and complete.

At the St. Louis session of the American Medical Association, May, 1922, there was a discussion before the Section on Ophthalmology on the use and abuse of the probe in the treatment of dacryocystitis in general. In discussing the congenital type, no reference was made to a method of treatment that has been successful in my hands for the last seven years, during which time I have never found it necessary to resort to the use of the probe.

The treatment is simplicity itself. A few others have practiced it in the past, but it has never been put before the profession in such a way as to cause its adoption in preference to the more difficult and painful method of probing. It is conceded, of course, that one successful passage of a medium size probe usually suffices to cure the condition (and, in rare instances, may have to be done), but an anesthetic is usually required to avoid the danger of unnecessary traumatism, and even then there is the danger of forcing a false passage into the nose or its adjacent tissues, to say nothing of the dangers from the anesthetic.

METHOD OF PROCEDURE

1. The tear sac is allowed to become fully distended. We caution the mother not to wipe the eye or in any way to press on the tear sac before coming to the clinic or office. She is given a 25 per cent. solution of protargin mild (argyrol) or other antiseptic eye lotion, to be dropped into the culdesac three times a day, to protect the eyeball from infection.

2. The infant's head is held between the surgeon's knees in a manner similar to the method in vogue of inspecting the eyeball. Assuming that it is the right sac that is affected, he places his right thumb over the sac in a way to shut off the return flow through the puncta. This is done by holding the thumb sidewise, with the thumb nail outward and forming an acute angle with the plane of the iris. The edge of the thumb is now pressed downward over the puncta, compressing it against the rim of the orbit; with this point of pressure maintained, the thumb is rotated to the right, at the same time pressing downward, abruptly, over the sac. The fluid, now being compressed by the thumb, transmits the pressure to the walls of the sac, which must give way at its weakest point, which happens to be the site of the nasal opening. Repeated cures after one manipulation of this sort, and no failures so far, extending over a period of seven years, convince me that the probe should never be resorted to except as a last resort.

The salient points to be remembered are: (1) Pressure must be made over the sac only when it is distended; (2) care should be taken that the thumb is applied in such a way as to prevent regurgitation into the conjunctival sac, and (3) sudden pressure over the sac causes the retained fluid to burst through the persistent fetal membrane which separates the mucous lining of the nose from that of the nasal duct.

COMMENT

On reviewing the literature of this subject further, we find little or no stress laid on this particular mode of treatment. The late Dr. Kipp, however, was a strong advocate of it. In the discussion of a paper on this subject by Dr. William Zentmayer, in 1908, he said:

> In all cases treated within the last ten years, I have used simply cleansing and pressure, and have not had to use a probe in any case. The cases that come with abscesses of the lacrimal sac are those that have been probed by other oculists. Cases that come to me within a couple of weeks after birth are cured in a very short time by simple cleansing and pressure. You must instruct the nurse or mother to exert pressure properly to direct the secretions downward. If you do it yourself, you can often feel the obstruction give way.

Fuchs, in the last edition of his textbook, dismisses the subject with the following remarks: "Usually repeated expressions of the lacrimal sac suffice to cure the disease; if not, we must make the nasal duct pervious by the use of sounds."

Roemer says that we need only to teach the mother to press the contents of the sac out regularly (meaning into the conjunctival sac), and the passage into the nose will open spontaneously. If the suppuration should not disappear in a few days, the stenosis may be easily removed by the careful passage of a probe.

Crawford makes use of pressure applied over the sac, and repeats this several times a day as an adjunct to other remedies.

Fage recommends expression, probing and incision if necessary.

Norris and Oliver [1] advise expression, and, in the event of failure, four or five probings with gradually increasing sizes.

Zentmayer is a strong advocate of the probe, while Jackson states that he avoids the use of the probe whenever possible, and relies on gentle pressure. When necessary to resort to the probe, he prefers one of moderate size, for, he says that this is not wholly without risk even in skilful hands, but the risk from attempting to force a passage with fluid from a syringe is at least as great.

The foregoing method, of course, is based on the assumption that we are always dealing with an imperforation at the nasal end of the duct. If the obstruction is due to a diverticulum or fold of mucous membrane, congenital stricture or bands in any portion of the canal, such treatment is of no avail, and, for that matter, probing would not suffice. On the contrary, it might do more harm than good. Such conditions are extremely rare, and treatment by any method other than extirpation of the sac is unsatisfactory.

The simplicity and efficacy of the treatment here described should appeal to the pediatrician, the obstetrician, and to the general practitioner as well, to whom these cases are first brought. If they will recognize the condition before infection has taken place, and will practice the procedure described above when the sac is distended with lacrimal secretion, and not with pus, they will relieve many a fond mother's anxiety by promptly curing the condition.

40 East Forty-First Street.

1. Norris and Oliver: Diseases of the Eye, Philadelphia, J. B. Lippincott Company, 1907.

Diphtheria Immunization of School Children.—The *Monthly Bulletin* of the department of health for April contained a report of the work of the bureau of laboratories, which shows that in 1922 more than 157,000 persons, chiefly school children, have been Schick tested and immunized, when necessary. This year's work has extended the number of protected school children in Greater New York to more than 250,000. Deaths from diphtheria continue to decline. The report announces that a modified Schick outfit has been devised which will be placed on the market within the next month, and eliminate the difficulties of the old capillary tubes due to breaking up of the column of toxin. Occasionally some of the toxin entered the closed ends of the tube, making the outfit useless. During the year the laboratory produced 1,411,300 c.c. of diphtheria toxin and 1,993,100 c.c. of diphtheria antitoxin. The value of the antitoxin was $135,245.80.

Clinical Notes, Suggestions, and New Instruments

RIBS FRACTURED BY COUGH

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The occurrence in three patients of fractured ribs following a cough, and the fact that none had been recognized by good clinicians, prompt the recording of these cases.

REPORT OF CASES

CASE 1.—*Fracture of fourth and fifth left ribs.* Mr. B., aged 34, with extensive pulmonary tuberculosis, was attacked with a very sharp pain in the left side following a severe nocturnal cough. The diagnosis of pleurisy was made. The side was strapped without relief. Finally, morphin had to be administered to control the pain and cough. The left lung having active disease throughout, artificial pneumothorax was attempted, but failed. As the disease was progressing, surgical collapse was decided on, and an operation was performed three weeks after the onset of the severe pain, which had persisted. To the surprise of the surgeon, two ribs, the fourth and fifth, between the internal border of the scapula and the spine, were found completely broken through, with little attempt at healing.

CASE 2.—*Fracture of sixth right rib.* Mr. K., aged 52, with an advanced condition of pulmonary tuberculosis in the right lung with cavity formation, during a spell of wet weather, while sitting in a rocking chair, coughed violently, and had a sudden severe pain located chiefly in the upper right abdominal quadrant. A diagnosis of diaphragmatic pleurisy was made. The patient was strapped, but this gave little relief because of the severity of the pain, and the fact that it was intensely aggravated by coughing. Morphin was administered. About a week later, after his arrival in Colorado, the patient was seen by us, and the diagnosis of fractured rib was suggested. The patient was quite obese, but by careful examination, a definite ridge across the sixth right rib, just below the angle of the scapula, could be made out. Occasionally a slipping motion, which the patient also would feel, could be detected. The pain lasted several months, and was always conspicuous over the upper abdomen on the right side. Very little pain was ever felt at the site of fracture, but discomfort was elicited on deep pressure. A roentgen-ray examination confirmed the diagnosis.

CASE 3.—*Fracture of ninth left rib.* Mrs. K., aged 58, who had pulmonary tuberculosis thirty years ago, now completely arrested, with no signs of activity for many years, and who was very susceptible to attacks of acute bronchitis, during a recent visit to New York contracted bronchitis. The cough was very severe and in paroxysms. Pain developed below the right costal margin, and the patient was treated for pleurisy. Two days later, severe pains developed in the lower axilla on the left side. The patient was then strapped for pleurisy, but with no relief. The distressing cough was controlled by opiates. On her return to Colorado Springs, the patient was still coughing and suffering severely. A diagnosis of fracture of the ninth rib on the left side in the midaxillary line was made. A definite ridge could be felt across the rib, and the patient was very sensitive over this spot. There was no pain at the termination of the nerve over the abdomen, but there was quite a severe pain on the opposite side in this area of distribution. Definite slipping could be heard with the stethoscope over the course of the rib, following a slight cough. A roentgen-ray examination showed a definite break of the ninth rib in the midaxillary line. Strapping, and opiates to control the cough, gradually brought relief, and the pain on the opposite side was also relieved at the same time.

COMMENT

So far, we have been unable to find mention of rib fractures resulting from cough in any textbook on diseases of the chest or on tuberculosis. On the other hand, textbooks on surgery and fractures frequently mention this association. Keen states that fractures of the ribs are rarely the result of violent muscular efforts, such as sneezing and coughing. Stimson says, "Fractures of the ribs may be caused by muscular action or by external violence. Of muscular action the most common form by far is coughing; others are sneezing, lifting a heavy object, even turning in bed." He also says it is much more common on the left side than on the right, and cites forty cases compiled by Tunis,[1] and thirteen personal cases by Chelmonski.[2]

Although Scudder does not mention cough as a cause of fracture, he says that pain may be felt at the seat of fracture on any forcible expiration, as in sneezing, coughing or laughing. The patient may be able to place his finger accurately on the seat of fracture, although this was not the case in any of our patients.

Von Bergmann-Bull states that fracture of the ribs has been reported after slight exertion, such as sneezing or coughing. In these cases, the fracture probably takes place during the violent expiratory efforts. It is a peculiar fact that most of these fractures were on the left side. This author cannot agree with Bahr, at least in cases of the upper ribs, that the liver protects on the right side. Most of these fractures were near the cartilaginous junction in the anterior third. None of those reported here were in this location.

Such fractures must occur more commonly than internists suspect. Sudden severe paroxysmal pains which persist in patients with pulmonary tuberculosis should suggest a search for a fractured rib. In these cases, cough is very troublesome and tends to make the broken ribs somewhat intractable in healing.

402 Burns Building.

SUPPORT FOR HERNIA, RELAXED SACRO-ILIAC LIGAMENTS AND VISCERAL PROPTOSIS

EDWARD J. BROWN, M.D., MINNEAPOLIS

The great comfort I have experienced leads me to describe this support in the interest of the thousands of sufferers from hernia, relaxed sacro-iliac and visceral proptosis.

I have worn hernial supports for thirty or more years with varying discomfort. About fifteen years ago, an orthopedic friend advised me to lie on a hard board for an attack of sacro-iliac lameness. After two hours I rebelled, went to my harness maker, and ordered a heavy surcingle of webbing 4 inches wide and three-sixteenth inch thick, fitted with straps and buckles one-half inch from the upper and lower edges. This was buckled tightly about my hips, and I then went about my business. For comfort and cleanliness I wore a double thickness of canton flannel underneath. This is 2 yards in length, which allows several thicknesses to be folded in front over the hernia, affording an extra protection from the pressure of the hernial supporter, which is worn outside the surcingle, and at its lower edge. As a later development, I had two 4-inch rolls of muslin sewed to the back of the surcingle above which the strap of the hernial supporter is placed. The lifting of the abdominal viscera by the surcingle greatly simplifies the task of the hernial truss.

TROUSERS SUPPORTER

In yielding to convention by discarding visible suspenders, I have found both invisible suspenders and tight belts an unsatisfactory substitute. Last year I bought a piece of upholsterer's 4-inch webbing, long enough to encircle the body with something to spare, sewed to it at the middle an old belt, to the upper border six buttons to which a pair of suspenders were attached, and to the lower border, at each side, a 4-inch roll of muslin about an inch in diameter, to afford a support for the trousers. A heavy tape, tied through the buckle in front and to the truss below, stabilized both. I have found this trousers supporter so comfortable and satisfactory that I have used it all the year.

No doubt an appliance maker can make an equally comfortable and much more expensive combination, but I see no

1. Tunis University M. Mag., November, 1890.
2. Chelmonski: Centralbl. f. Chir., 1901, p. 1188.

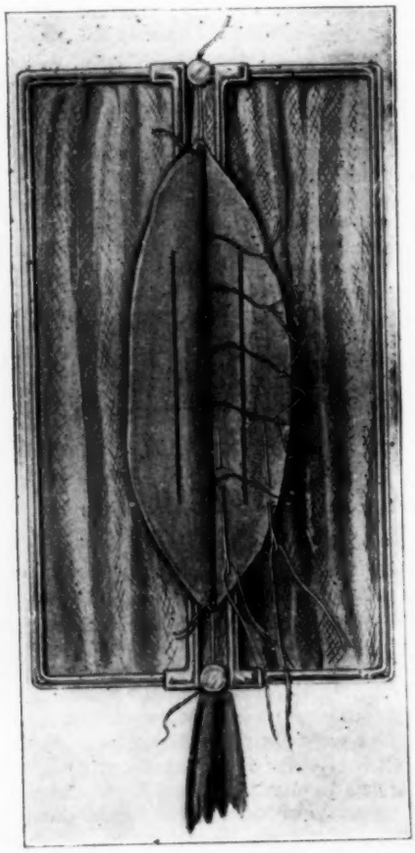
reason why the average person desiring such supports should not be enabled to fit himself with this perfectly simple combination automatically adaptable, comfortable and inexpensive.

900 Nicollet Avenue.

A GASTRO-INTESTINAL HOLDER FOR VISCERAL ANASTOMOSIS

CHAUNCEY E. TENNANT, M.D., DENVER

Modern visceral surgery has been much simplified during the last ten years. Prior to this it was deemed necessary to use clamps for hemostasis, both in gastro-enterostomies and intestinal anastomosis.



Gastro-intestinal holder for visceral anastomosis.

Many have been the clamps devised for this purpose, and perhaps the most popular of all has been the compound three bladed clamp known as the Roosevelt clamp. I had much to do with its development, and used it first, after many experiments, in the early days of gastro-enterostomy. While many surgeons still find this clamp very satisfactory, and seldom, if ever, have postoperative hemorrhage directly traceable to its use, yet reputable and successful surgeons have had this misfortune, and I am willing to concede that such accidents will happen, especially when this instrument is used as a *clamp* rather than as a simple, light hemostat and holder.

In order to afeguard the patient from this unfortunate experience, and to meet the objection of these well known surgeons, I have devised a simple visceral anastomotic frame to meet the needs of a visceral holder for modern anastomosis. Its weight approximates that of the original Roosevelt clamp, so that it steadies the visceral contents, without the aid of an assistant's hands, which are so often in the way. The middle blade, or holder, is discarded and two anchoring catgut strands are used in its stead, thus better approximating the structures to be anastomosed, and also to facilitate the placing of a gauze strip underneath and between the two viscera. The blades are then approximated close up to the outer margins of the viscera sufficient to hold them firmly; yet the pressure from these lateral blades is so light that it is impossible to produce necrosis or postoperative hemorrhage. The tissues now being held firmly in position in the center of the frame, the operator may proceed without assistance, especially when the Balfour retractor is in position.

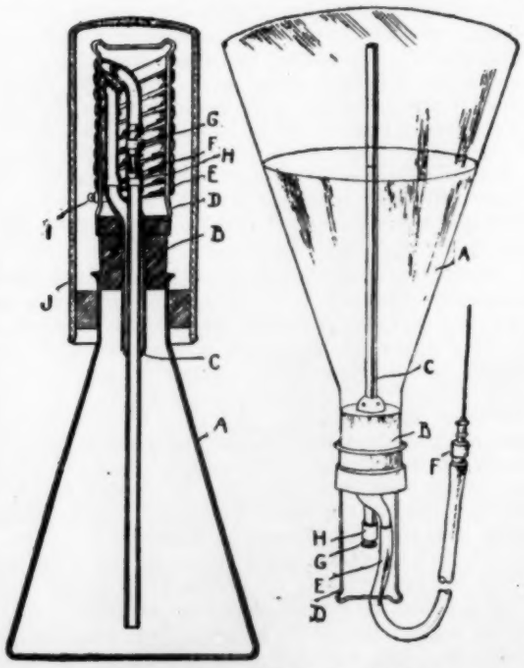
A much better stoma may be made and a decidedly better approximation, because the tissues are free to give when more margin is required. The few blood vessels along the greater curvature are ligated, both above and below the stoma, after fixing the organ in the holder, and before the opening is made. In intestinal anastomosis this is, of course, unnecessary, although the holder works equally well here. The handle is removable, making its use optional with the operator.

A NEW APPARATUS FOR THE ADMINISTRATION OF FLUIDS *

EDWARD F. LANE, NEW BRUNSWICK, N. J.

This apparatus has been designed with a view to providing a safe, easy method for the intravenous, intramuscular, intraperitoneal and subcutaneous administration of fluids—saline, glucose and sodium bicarbonate solutions. It is simple and at the same time surpasses in asepsis, convenience and adaptability any apparatus at present in common use.

The instrument consists of a flask (*A*) of any desired capacity, though I have found that one of 500 c.c. is the most suitable for general use, with the highest graduation at the top, provided with a rubber stopper with a single hole (*B*) through which passes a glass tube (*C*) so constructed that it at the same time empties the flask and admits the air necessary to empty the flask. Attached to the rubber stopper is a framework (*D*) of German silver, on which the rubber tubing (*E*), of sufficient length to allow a good head of pressure, is conveniently wound. The apparatus, when packed, is self-sealing by means of two adapters, one of which (*F*) is attached to the rubber tubing, and so provides a quick, sure attachment for the needle, and the other (*G*) is attached to the second outlet of the glass tubing by means of a rubber connection (*H*) to give pliability and so prevent breakage. The adapter *F* is slipped into the adapter *G*, and the rubber tubing wound around the frame and fastened by



Apparatus for administering fluids.

* From the Department of Pathology and Experimental Medicine, Middlesex General Hospital.

means of the lug (*I*) provided. A glass cover (*J*) fits over the top of the flask, enclosing the rubber tubing, frame, stopper and adapters, so that no dust or organisms can enter.

To prepare the apparatus for use, it should be filled, sealed, and sterilized in an autoclave, and is then ready for use. It can be easily carried in the physician's bag or placed in a convenient place in the operating room.

The preparation of sodium bicarbonate solution is somewhat different from other solutions, because of the fact that it is broken down by the heat in autoclaving. In the preparation of it, after autoclaving, carbon dioxid is bubbled through the solution for several minutes to replace that which was lost. The adapter is cleansed with alcohol and the flask is sealed again for future use.

In the physician's bag there is no danger of leakage when the flask is placed on its side, provided the stopper and adapters have been securely placed.

REMOVAL OF ADHESIVE BANDAGE

HARPER F. ZOLLER, DETROIT

Medicated tape or adhesive bandage can readily and painlessly be removed from the patient by moistening the bandage with a little pure ethyl acetate held in absorbent cotton, by sopping lightly over the entire surface of the bandage or tape. In a few seconds the adhesive surface is killed and the bandage can be pulled free from the skin or hairy surface without the least "pull" to the patient. The ethyl acetate possesses a rather penetrating odor, but, because of its high vapor pressure, it evaporates entirely in a few minutes, leaving neither odor nor ill effect.

When the adhesive tape or bandage covers areas or surface which may become infected, a few drops of tincture of iodin or a few crystals of pure iodin may be added to the ethyl acetate (the latter is an excellent solvent for iodin) for purposes of disinfection. The solution may then be used as before for the removal of the bandage.

REMOVING ADHESIVE SPOTS

It is frequently necessary to remove from a skin surface the grimy portions of adhesive left from strips of tape torn away by other means. Ethyl acetate on a tuft of absorbent cotton will do this nicely. Ethyl acetate acts as a solvent for a portion of the body of the adhesive, and this is a very safe and satisfactory solvent to employ about the sick or convalescent ward. There are other esters that can be employed in lieu of ethyl acetate, but it is doubtful whether they will ever be as suitable both from the odor, vapor pressure and economic standpoints. Several physicians and hospital attendants who have tried this solvent at my suggestion have praised it highly. I present it herewith so that others may benefit too.

COMMENT

It is no uncommon experience to have nurses and attending physicians in hospitals and homes tear the adhesive bandage loose from the patient, at the expense of pain and ill feeling. Whenever the hair has not been shaved, this mode of operation causes additional discomfort. Frequently recourse is had to gasoline and other solvents, but gasoline may prove very unsatisfactory at times; nor is it as good a solvent for the adhesive. A small bottle of ethyl acetate in the physician's kit or in the medical chest of the hospital, or further, in the first aid cabinet, will greatly lessen the torture from adhesive bandaging.

3345 Grand River Avenue.

Introduction of Disease in Brazil.—Smallpox prevailed in Brazil from remote times; trachoma was brought by the negro slaves in 1830; scarlet fever appeared in 1835 from Argentina; typhoid fever was imported from the Canary Islands in 1836; measles epidemics occurred in 1834 and 1844; yellow fever, after putting in brief appearances in 1555, 1685-1692, 1828, 1839 and 1842, finally became endemic in 1849; cholera arrived from Europe in 1855, causing about 200,000 deaths; plague was imported in 1899.

New and Nonofficial Remedies

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED AS CONFORMING TO THE RULES OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR ADMISSION TO NEW AND NONOFFICIAL REMEDIES. A COPY OF THE RULES ON WHICH THE COUNCIL BASES ITS ACTION WILL BE SENT ON APPLICATION. W. A. PUCKNER, SECRETARY.

SOFOS.—A mixture of sodium dihydrogen phosphate and sodium hydrogen carbonate (sodium bicarbonate), rendered stable by coating the particles of one of the constituents with sugar (2 per cent.). One part of sofos has the same phosphate value as 1.75 parts of sodium phosphate, U. S. P.

Action and Uses.—When sofos is treated with water, sodium phosphate (Na_2HPO_4) is formed and carbon dioxide is set free. (The reaction does not go to completion, some sodium dihydrogen phosphate remaining; but this is not considered important, as primary phosphate is also formed when sodium phosphate is taken into the acid gastric fluid.) Sofos has the physiologic action of sodium phosphate. It differs from the effervescent sodium phosphate preparations in that it is free from citrate or tartrate.

Dosage.—For adults, from 5 Gm. to 15 Gm. (from 1 to 4 drams) in a glassful of water, taken before effervescence ceases.

Manufactured by the General Chemical Company, New York City. U. S. patent 1,037,078 (Aug. 27, 1912; expires 1929) and 1,150,901 (Aug. 4, 1915; expires 1932). U. S. trademark 116,426.

Sofos is a white powder, having a slightly acid taste. It is permanent in dry air. On the addition of water, effervescence occurs with formation of secondary sodium phosphate and evolution of carbon dioxide. (When treated with water at room temperature, about 70 per cent. of the available carbon dioxide is liberated; when treated with human gastric fluid, about 93 per cent. of the available carbon dioxide is set free.)

Assay.—Dissolve about 0.5 gm. of sofos, accurately weighed, in 100 Cc. of water, and, after effervescence ceases, acidify with a small excess of hydrochloric acid. Boil the solution until the carbon dioxide is removed, cool and render ammoniacal. The phosphorus content is then determined in the usual manner, weighing as magnesium pyrophosphate. The amount of phosphate radical (PO_4) present should not be less than 46 per cent.

POLLEN EXTRACTS-P. D. & CO.—Liquids obtained by extracting the proteins from the dried pollen of various species of plants. The products are standardized in "units," a unit being the extractive obtained from 0.002 mg. of pollen.

Actions and Uses.—See Pollen and Epidermal Extract Preparations and Biologically Reactive Food Proteins, New and Nonofficial Remedies, 1923, page 234.

Dosage.—See Pollen and Epidermal Extract Preparations and Biologically Reactive Food Proteins, New and Nonofficial Remedies, 1923, page 234.

Pollen Extracts-P. D. & Co. are marketed in the following forms: (1) A package of 5 tubes for diagnostic purposes, each tube containing enough solution (1,000 units per cubic centimeter) for one test. (2) For diagnosis, prophylaxis and treatment, one set of four bottles of 5 Cc. each, representing graduated concentration, namely: No. 1, 10 units per cubic centimeter; No. 2, 100 units per cubic centimeter; No. 3, 1,000 units per cubic centimeter; No. 4, diluent consisting of physiological solution of sodium chloride. (3) For diagnosis, prophylaxis and treatment, 1 bottle of No. 2, 5 Cc., 100 units per cubic centimeter. (4) For diagnosis, prophylaxis and treatment, 1 bottle of No. 3, 5 Cc., 1,000 units per cubic centimeter.

Manufactured by Parke, Davis & Co., Detroit, Mich.

Pollen Extract Ragweed-P. D. & Co., and Pollen Extract Timothy-P. D. & Co., are prepared by the following method:

The dried pollen is ground in a ball mill with physiological solution of sodium chloride and sand for five days, after which the suspension of pollen in solution of sodium chloride is mechanically shaken for twenty-four hours. It is then clarified by filtration and standardized, so that each cubic centimeter contains the extract from 2 mg. of pollen. Weaker solutions are prepared by diluting with physiological solution of sodium chloride.

PROCEEDINGS OF THE SAN FRANCISCO SESSION

MINUTES OF THE SEVENTY-FOURTH ANNUAL SESSION OF THE AMERICAN MEDICAL ASSOCIATION, HELD AT SAN FRANCISCO, JUNE 25-29, 1923

(*Continued from page 1938*)

HOUSE OF DELEGATES

First Meeting—Monday Morning, June 25

The House of Delegates met in the Civic Auditorium, San Francisco, and was called to order at 10 a. m. by the Speaker, Dr. F. C. Warnshuis, Grand Rapids, Mich.

ADDENDUM

(Refer page 1911, preceding Reports of Officers)

The Vice Speaker, Dr. Rock Sleyster, Wauwatosa, Wis., was called to the chair, after which the Speaker delivered his address.

Address of the Speaker, Dr. Frederick C. Warnshuis

Members of the House of Delegates:

In opening the deliberations of this House of Delegates, I am again confronted with the duty of calling to your official attention the death of an officer of our association.

On Sept. 2, 1922, Dr. Alexander R. Craig, our Secretary, answered the final summons that terminates man's earthly activities. We mourn his death and voice our loss. We revere him in our memory far more sincerely than words can express. We pay tribute to him for years of activity and service that he contributed to our organization and for what he was as a man, possessed of noble and endearing qualities that commanded our respect and admiration. There was much in his life and work that we failed to recognize, fully interpret and adequately appraise. As he mingled among us, he exercised an influence that was elevating and inspiring. We shall miss him in our deliberations.

With your approval, I am appointing a special committee composed of Drs. Dowling of the Board of Trustees, Donaldson of Pennsylvania and Taylor of Texas to formulate suitable resolutions to be spread on our records for the better recording of our testimonial and tribute to our deceased co-worker and Secretary, Dr. Alexander R. Craig.

Mr. Vice Speaker, shall we rise, and with bowed heads, pay respect and honor to him who so long was one of us but now rests in eternal sleep?

. . . . . .

As delegates, representing component units of our national organization, we are assembled in annual session for deliberation and the enacting of policies and principles that your combined wisdom and judgment proclaim are paramount for the better achievement of the objects that formulate the foundation of our Association, and which justifies its existence among the institutions and people of this nation. A duty and trust is assumed by every delegate and rests on this house as a whole. It is imperative that, individually and collectively, we recognize our obligation when participating in the business of this legislative body. By the agency of events which are now happening, the old landmarks and courses are fast disappearing. Experience is robbed of half its value. New difficulties obstruct our paths, new burdens weigh us down, while new and more serious problems, which are certainly approaching, must be averted from our national and state organizations. Our individual relationship to patients and the public is rapidly passing through a transitional stage, with changes that shall ever after mark an era in our professional history. We stand as actors on the stage, and in these occurrences and events, as we appear in the scenes, we are confronted with a duty that calls on us to strive honestly and earnestly to understand the philosophy of these events and to recognize the weaknesses of our organization. If we are imbued with such a zeal and spirit, we can turn our faces to our constitutents, and to the people, voicing our pronouncements and attitude with a serenity and sincerity that will at once command confidence and approbation.

It may seem superfluous that I should voice a plea for unity of purpose and sincerity of action that is void of all semblance of personal ambition. In doing so, I recognize that this session will mark the enactment of policies that will direct our associational activities into new channels and toward strange objectives that will either uproot our foundations or enhance our activities. To that end, then, let me urge that you acquit yourselves of the trust that has been reposed in you so that no man can impugn your acts or motives.

Your Speaker does not presume to direct your deliberations. I avail myself, however, of the opportunity of briefly calling to your consideration certain outstanding features that should command your attention and thought.

SEMIANNUAL SESSIONS OF THE HOUSE OF DELEGATES

In my address one year ago it was recommended that earnest consideration be given to the advisability of holding semiannual sessions of the House of Delegates. In this recommendation I was supported by President de Schweinitz. The Reference Committee did not deem it expedient to recommend the adoption of that plan.

I am fully aware of the expense that would be entailed by reason of such a midyear session. I also recognize the demand that would be made on the time of the delegates. Nevertheless, I desire to repeat that recommendation. The conditions under which we are living and the relationship we bear to these changes indicate that we cannot progress without undergoing profound changes ourselves. The problems that come before us for solution are momentous. They merit more deliberate consideration than can be given them in the four days that we now annually devote to our discussions. It would therefore seem wise and for our profession's interest that we accord more time and more deliberation in the formulation and promulgation of plans and policies that are of such vital concern to our future. To do so we must provide for an extra session. It is recommended that the requisite amendment be introduced, and until it can become effective, that you authorize your Speaker to call an extra session of this House at a time deemed most expedient by the Trustees in the month of January, 1924.

SECTION RESOLUTIONS

Last year we had the inconsistent incident of this House of Delegates formulating a policy and enunciating a position in regard to the Shepard-Towner Law. During the same session one of the scientific sections assumed to adopt a set of resolutions which in word and purport was diametrically opposite to the opinion and position expressed by this House of Delegates. This situation embarrassed many state society legislation committees in their legislature activity. To prevent a repetition of such a situation it is recommended that the Scientific Assembly as a whole, or as component sections, shall be interdicted from voicing policies, opinions or recommendations of the Association; that when, in the opinion of the Scientific Assembly or any of its component sections,

public pronouncement on any scientific subject or public policy is deemed expedient, then the section delegate from the section wherein such action may arise shall present the resolution or recommendation to the House of Delegates, and that this House shall be the only official body empowered to adopt or convey to the public opinions, recommendations or policies of our national association. The wisdom of this recommendation must be self apparent, and while I am aware that such a provision does now partly exist, it is urged that emphasis be given to it by the adoption of a new amendment to be formulated by the Reference Committee that sets forth such specific provisions, and that section officers be instructed annually as to its enforcement.

SOCIALIZATION OF MEDICINE

"State medicine" was defined by this House during our last session. That definition is clear and conclusive. I assume that the formulation and adoption of that defining statement was for the purpose of establishing a policy and a principle for the guidance of our state and county units. I assume, further, that activity, on the part of members individually, collectively or as public officials would be subject to the jurisdiction of component units of which they are members when the provision of that resolution was violated. The events of the past year, in many states and localities, are indicative that but little, if any, consideration has been given to the policy enunciated. It is apparent that certain members assume that they and their associates are neither amenable nor subservient to the acts of this body; that they are self-sufficient and supreme unto themselves.

If we are to endure, if we are to be more than word formulators, if we are to exercise full organizational prestige and influence, then it becomes imperative that every member of this Association be made to realize that our policies are not idle compositions or vague or visionary speculations. To remain affiliated with this national body, it must be impressed on those who comprise its membership that such membership entails the willingness to keep inviolate the laws and rules that govern our federacy. I therefore deem it advisable that you direct that a compilation of the policies of this Association be promptly undertaken by the Secretary; that this compilation shall plainly set forth the position that state and county units shall assume in meeting the problems of public health movements and in particular to the activity of group clinics, community and hospital clinics, national and state health clinics, health boards and health officers; that this compilation shall conclude with the statement that any action controversial to the announced policies of this Association, either by individuals, groups or component units, shall be submitted to review by state councils and our Judicial Council, and subjected to such action as these respective bodies many deem advisable. Further, that our Secretary be instructed to cause the distribution of such compilation to be accompanied by a letter directed to state and county officials conveying the recommendation of this House that they take requisite action that will obtain a general observance of the policies enunciated by this body.

I distinctly wish it understood that I do not criticize efforts directed to strictly public health measures. These have our unqualified support. But when that purpose is used as an excuse to justify the institution of socialized medicine for all classes of society, and in so doing condemnation and ridicule are directed to the profession as a whole, as well as to individuals, we emphatically declare that the time has come to call a halt and that they who thus conduct themselves shall be called to account; that their right to continue as members of this organization shall be inquired into, and if the facts reveal that they are unworthy, that their membership shall be promptly terminated.

Unless we insist on a united observance of our policies, then as an Association divided in opinion and action, we surrender our right to every prestige and the public acceptance of our recommendations. A much twanged string is the subject of cooperative unity of purpose and deed. Unless we cease our twanging and create unity of action, it would be better for us to renounce every intent or purpose of participating in the deliberations of those who are conducting the councils of this nation and who seek the solution of its problems. The past year has witnessed attack after attack on the integrity of our profession in many legislatures. Our response, our refutation of the charges, our requests and recommendations received but scant consideration. A few years hence they will obtain no consideration, unless we become unitedly active in the reestablishment of a unity of purpose that is not nullified by the derogatory words, acts and attitude of individuals and special groups holding membership in our association. I emphasize again that this subject merits your serious consideration and deliberate action. I further recommend that, if a midwinter session of this House is determined on, you authorize your Speaker to appoint a special committee that will present a detailed discussion of the situation and present such recommendations as to plans to be adopted that will lead to the creation of organizational influence and power in the legislative and health movements of this nation.

An association and activity extending over a period of eighteen years of organizational work and executive duties with a faithful study of our problems cause me to conclude that this is the most momentous and important subject that now confronts us and presses for solution. And unless we do concern ourselves with it, we might as well rewrite the preamble and object of our federacy and openly announce that, as an organization, we are concerned only with the scientific features of our profession, and withdraw from further participation in matters of public concern and public consideration. It remains for you, the members of this House, to determine whether we shall conserve and strengthen our Association and cause it to be an organization that exercises a potent influence in national affairs, or whether we shall withdraw from the public arena and concern ourselves only with purely scientific topics.

NATIONAL WELFARE DEPARTMENT IN THE PRESIDENT'S CABINET

During the first of the year there was called for conference with President Harding's personal representative a group of men, representing several medical organizations of this country, for the purpose of discussing plans for the organization of a national welfare department in Washington under the control of our national government. At this conference our Association was represented by but one individual. It may be anticipated that several such conferences will be held during the coming months. I recommend that the House of Delegates designate a special committee that shall be instructed to represent this Association at such future conferences. It is recommended that that special committee shall consist of the President, Secretary, Chairman of the Board of Trustees, Executive Secretary of the Legislative Bureau and the Speaker of the House of Delegates. If this recommendation is concurred in, it is further recommended that the Secretary be instructed to inform President Harding's personal adviser of the action taken. It must be self-apparent that this Association should be adequately represented in these important deliberations.

FIELD SECRETARY

While undoubtedly our Board of Trustees has been mindful of the need of securing an efficient Field Secretary, it is urged that they be directed to secure at the earliest possible moment a capable representative to fill that office and to perform its duties. Never was it so imperative as now that the cooperative efforts of our component state units should be enlisted and made effective for the furtherance of our organization and individual interests. The need presses for a directing liaison officer. Unnecessary delay should not be permitted in his selection. Generous monetary remuneration should be appropriated to secure a capable Field Secretary.

RED CROSS MEDICAL ACTIVITY

We reiterate that no need now exists for the entrance of this great war-time organization into the field of public health work or community clinic work. It is recommended that such representation be expressively made to the officials of the Red Cross by such representatives of this Association as you, in your judgment, deem most expedient and efficacious.

NURSES AND NURSES' TRAINING SCHOOLS

We commend most heartily the work that has been so efficiently undertaken by the special committee of the Council on Medical Education and Hospitals in the study of the problem of Nurses and Nurses' Training Schools. It cannot be expected that their work could be terminated in the brief space of one year. It is recommended that that committee be continued and that it be instructed to remain active in the performance of its task until a successful solution of the problem has been formulated and instituted.

BOARD OF TRUSTEES

It has been my privilege to attend the sessions of our Board of Trustees during the past year. I desire specifically to record the opinion that our Trustees individually and collectively assume the responsibility placed on them with but one motive—the best interests of the Association and its members. I am convinced that its deliberations and actions are void of every semblance of selfishness. There is wholly no evidence of any intent to assume dictatorship, closed corporation policy, or the tendency to group, district or class protectionism or favoritism. Our trust has been well placed and its administration is conscientiously executed. Our Trustees merit our every confidence.

While it is desirable to have sections of our country represented on our Board of Trustees, I am of the opinion that individual merit should be recognized and that the Trustees who manifest such merit and contribute such desirable service and zeal should be perpetuated in office just as long as it is possible to receive those services that reveal satisfactory accounting of their stewardship and confirm the implicit confidence that we have placed in them. I desire emphatically to repudiate the charges and allegations that apparently arise from the disgruntled who as yet have revealed not a single trait or contributed a single suggestion for the betterment of our Association. I am convinced that he who has carefully, and with some degree of hypercritical attitude, studied and observed the action and activity of our Board of Trustees must come to the same conclusion and opinion. I seek simply to convey to you the conclusions reached by reason of personal observations on the part of your Speaker.

BULLETIN OF THE ASSOCIATION

By your enactment, the Speaker of the House of Delegates is designated as an associate editor of the BULLETIN. It is impossible and inexpedient for him to participate in its editorial management. No basic reason exists for him to serve in that capacity, for in the interval between the sessions of this House, the Speaker is possessed of no executive powers.

The BULLETIN is of but limited value in that it is of limited circulation. Its content matter should be made to reach our entire membership. Every member should be enlightened as to our associational activity, and be fully conversant with that which we are seeking to attain. If a need exists for more intimate communication between our general headquarters and officers of component units, that need can be supplied by means of monthly letters from our executive officers.

It is recommended that the BULLETIN be discontinued and that in one issue, each month, sufficient space be allotted in THE JOURNAL to our Secretary and Field Secretary for the presentation of that which is being done along organizational lines. I am of the opinion that, as our members recognize what this Association and its component units are accomplishing, there will be awakened greater interest, more complete confidence and a more pronounced desire to subscribe personal support to local, state and national bodies. THE JOURNAL of our Association should be utilized to give to all our members the information that is now being published in the BULLETIN.

FULL-TIME SECRETARIES

I proffer the suggestion that our Board of Trustees, if it meets your approval, be directed to arrange so that desirable individuals may be taken into the offices of our national headquarters to receive requisite training that will qualify them to accept positions as full-time secretaries of our state societies.

If we are concerned, as we needs must be, with the influence that current events are exerting on our profession, considerate thought must be given to the training of men who shall represent us in the councils of our several states and of the nation. We should cause to be created a corps of trained state executives whose services will be available to our state societies. Several of our state societies have full-time secretaries. Some smaller states possibly could not afford them; but, in such instances, one trained man might well and efficiently represent and direct the organizational work of a coalition of several states.

RULES OF THE HOUSE OF DELEGATES

During the year, for the sole purpose of more expeditiously and effectively conducting the transactions of the House of Delegates, I addressed a letter to each delegate soliciting suggestions and criticisms of the methods now in vogue. A representative response was received. These communications were carefully and thoughtfully studied and discussed with the Secretary. Two recommendations predominated: the first, that sufficient time was not provided for more deliberate and broader discussion of the questions that arose or the resolutions that were presented; the other, that committees have insufficient time to consider referred business, and that full opportunity is not always afforded at committee hearings.

Your Speaker has repeated his recommendation for a mid-year session to provide greater opportunity for fuller consideration of the business that arises within this body. That is the only solution, unless we extend our annual session.

To meet the other recommendation, your Speaker sought to appoint the Reference Committees in advance of this session, and thus provide opportunity for more thorough study of the reports that are submitted to them in advance of our meeting. I felt that they could then devote more time to committee hearings. However, our by-laws prevented the taking of such action. I believe that such a plan would be most expedient. If it appeals to your judgment, it is recommended that a change be effected in the by-laws that will validate the Speaker's appointment of reference committees thirty days previous to our meetings. It is recommended that the Reference Committee submit such an amendment for adoption at this session.

During this annual meeting I will endeavor to announce at each session the time and place of all committee meetings. Reference committees are requested to adopt the policy of giving the greatest latitude and the largest possible amount of time to hearing the arguments of those who desire to appear before them. I realize the work that devolves on committeemen, but feel assured that they will undertake their duties and unselfishly contribute their time so as to afford wide opportunity for hearing the views of all who appear before them.

CONCLUSION

By your sufferance you permit me the sincerely appreciated honor of presiding for a second time during your annual session. I have sought to meet the confidence and trust imposed. Your Speaker openly avows that but one motive governs him in the performance of his official duties, and that is to cause this House of Delegates to recognize that it represents before the world the medical profession with all its ideals, hopes, ambitions and humanitarian principles. In thus representing the medical profession of this nation, this House of Delegates purposes by its enactments, the enhancement and maintenance of confidence and trust on the part of the public whom we serve. The great end sought is that we shall be better doctors and better men.

Address of President George E. de Schweinitz

The Speaker introduced the President, Dr. George E. de Schweinitz, Philadelphia, who delivered the following address, which was referred to the Reference Committee on Reports of Officers.

Mr. Speaker, Members of the House of Delegates, and Ladies and Gentlemen:

One year ago an address as President-Elect contained in its opening paragraphs some of the favorable impressions of the activities of the Central Offices gained during the period

of the business which pertains to that position. An additional year of duty, now completed, has served to increase in firmness such impressions, which have become settled convictions.

But it is altogether fitting and proper that a moment or two shall be occupied in speaking of our Board of Trustees, and what I shall say is not based on casual knowledge, but on intimate acquaintanceship and association which it has been a privilege to enjoy. The earnestness and fidelity with which the members of this board and the Editor-Manager perform their duties; the insistent, untiring attention which they devote to the work which falls to their share in solving and considering the numerous problems called to their attention, highly deserves our gratitude and our admiration. They work for the work's sake; they strive for the common good of our Association, the largest of its type in the world today, and, we fondly believe, the best.

THE BOARD OF TRUSTEES

The success of any large organization and its steady advancement must always be associated with supervision made possible through a Board of Direction. And in this respect *our* Board of Trustees has given us an unselfish service. Naturally, in a great organization such as ours, differences of opinion as to its policies and methods of procedure arise, and it is wise that they should exist. But, as Dryden said, "They wholly mistake the nature of criticism who think its business is principally to find fault." Not at all. From the days of Aristotle to our own, it was meant to be a standard of judging well, and if so utilized, and being constructive in character, is always a basis of improvement in effort and accomplishment.

The conviction of one man may differ from that of another, and all of us will surely agree with Huxley that "there is no one of our surest convictions which may not be upset, or, at any rate, modified, by a further accession of knowledge." Such knowledge finds one of its most direct pathways along the avenue of proper suggestion and criticism, which are therefore always welcomed. Indeed, discontent itself possesses a quality of importance in this respect, not the discontent which Emerson defined as "an infirmity of the will," and which, as has been said, is petty and personal, but that discontent which one of America's most distinguished essayists has described as one which has in it "a notable attribute of grace."

Working thus for the best interests of the Association, endeavoring with effective result to meet the obligations imposed by their office, the Board of Trustees, sustained by the courage of their convictions, arrived at after careful investigation, and helped by the suggestions and judgments of others, have established a record which has prominent place on the credit page of the ledger of our National Organization. On this day of parting, I take this opportunity, in the presence of this distinguished body, to express my congratulations to our Board of Trustees and the Editor-Manager, and to convey my thanks in that the privilege and profit have been mine to be present at most of their deliberations during the past two years.

Both the presidential address of last year and that to the House of Delegates were concerned in part with reference to medical instruction, and contained certain suggestions and recommendations related to undergraduate, graduate and medical-extension education.

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

In referring to the work of the Council on Medical Education and Hospitals, an appeal was made that this Council should include in its next yearly deliberation on the undergraduate curriculum the views of senior and qualified students and recent graduates of medicine as to changes in its construction. Evidently a similar thought was in the mind of its distinguished chairman, and all those who attended the instructive sessions last March listened with interest to the data which a questionnaire sent out from his office was able to gather.

Since then, in more than one county society an evening has been devoted to medical education and its problems, and in one at least, my own county society, by no means the least important discussion came from a recent graduate in an essay written entirely from the standpoint of the undergraduate. Such cooperative work, which may well be recommended to other county societies, and be further elaborated, is sure to be of material assistance in the work of reconstructing the undergraduate curriculum, which, in spite of the large attention which it has received, is still far from satisfactory.

The amount of attention which should be paid to the manifold specialties is always an insistent, and at times, one might almost say, an irritating one. Far from lacking investigation, this becomes more prominent in discussion, and received, as you know, comparatively recently, a full measure of consideration in the opening address of an important continental congress on internal medicine. Opinions as to how these problems shall be met have ranged from the obviously improper and stupid one that they, the important special branches, shall be eliminated from the curriculum and their instruction delegated entirely to a postgraduate period, to the equally and obviously improper and stupid one that the hours assigned shall be greatly increased and the curriculum cumbered with technical teaching and special instruction which manifestly *does* belong to the postgraduate years.

Conferences between teachers of the fundamental branches, and those of the so-called specialties, often, for reasons which are evident enough, have not resulted in satisfactory agreements. It is time to stop the constant academic discussions which have surrounded this problem, and to stop talking about this and that "course," and the "number of hours" which shall be accorded to one or the other, and to endeavor to ascertain of how much value the time spent on certain specialties during the undergraduate years has been to the practitioner of medicine in the largest acceptation of that term, in his professional life. This has been attempted by one specialist, in this case an ophthalmologist, by writing to one hundred graduates of an important eastern school of medicine, and it is interesting to observe that less than 10 per cent. believed that such instruction should be eliminated from the curriculum, while the others acknowledged, in greater or less degree, the value of such instruction in their practical work, and had no thought that it should be discontinued.

All this is a preamble of the suggestion or recommendation that from the Central Offices a questionnaire of much larger scope shall be sent to graduates of representative schools of medicine in various parts of this country prior to the next meeting on medical education in Chicago, and an analysis of the replies shall be presented as a basis of discussion as to how the departments of special instruction in undergraduate years can best be utilized.

The evaluation of such departments should not be determined alone according to the number of "hours" assigned to each, that is, according to a percentage of the whole number of hours required by the curriculum, for it is also high time to get away from the limitations imposed by thinking alone in the terms of giving "such and such a course," of which expression the incoming President of this Association says he is "thoroughly sick," and well he may be.

Without for a moment permitting the departments which by common consent are described as specialties to lose their autonomy, their value to the student of medicine as an essentiality in his general education and future career can readily be exhibited without the addition of a single hour to the proportion of independent hours which should be assigned to the department concerned, and without increasing the total number of hours comprised in the curriculum, if their intimately important relation to the fundamentals, medicine, surgery and obstetrics, is also blended into the scheme of general instruction, not in casual mention, but in definite demonstration.

If it is true, as has recently been said, that the basis of teaching should be sought in training exact observation, such a plan should be a useful method of procedure. Viewed from this standpoint, it has been discussed by Dr. Wilbur, it was touched on by various physicians in the Congress on Medical Education last March, and has been previously referred to in less exact terms by the present speaker (not the Speaker of the House, although I believe he is in accord with the thoughts expressed).

But no definite plan which may be recommended by the Council on Education has been formed, and therefore this is

again a preamble of a recommendation that a subcommittee of that Council, or, if preferred, of one chosen by direction of the House of Delegates, shall be formed to take this matter into exact consideration; and I frankly hope, should such a committee be organized, that I may have the privilege of consulting with its members in their deliberations, or if not, some member of my staff who is familiar with the methods we are endeavoring, we believe with satisfaction, to put into operation in the school of medicine with which I am associated.

The impetus which systematic graduate medical educatfon and its great department, medical-extension education, has received within the last few years is known to the satisfaction of all, and the effort and encouragement along these lines which have emanated from this Association, its officers, Councils and members, have had a large influence in the notable achievements which have been and are being attained. No recommendation is required to stimulate still further this advance in medical education.

FOREIGN MEDICAL-EXTENSION EDUCATION

Accustomed as we are to obtain the advantages of visits from foreign physicians and to welcome them to address our scientific meetings, and in turn to accept invitations from medical gatherings abroad to participate in their deliberations, the time is ripe, I think, to go a step further and establish what may be called foreign medical-extension education.

For this purpose the machinery of the American Medical Association, synchronized with that of similar associations in the available countries of Europe, could be utilized. A bureau should be established wherein the plans of systematic cooperative work could be formulated and put into operation. The unusual success and satisfaction which attended a comparatively recent series of lecture-demonstrations on ocular pathology, presented in a number of cities of our country, and engineered by the local societies, is an example of the admirable results which are obtainable in such circumstances. During a recent visit in England and Scotland, it became evident that such a plan would be welcomed, that it would be mutually beneficial, and that it would prove to be an important method of rehabilitating international scientific effort. It is hoped that the House of Delegates will accept this recommendation for consideration and action.

WORK OF THE PRESIDENT

Although the duties of the President of this Association are defined in Chapter V of the By-Laws, the sphere of his activities is by no means as limited as the words of Section 1 seem to imply. He can always concern himself with the duty of large opportunities freely offered.

During the periods of his incumbency, his participation in the deliberations of the Board of Trustees and of those of their Executive Committee is welcomed; he is always free to make recommendations which receive sympathetic and careful attention and the required action; he is the recipient of numerous cordial invitations to attend medical and state and society meetings from all over the country; his desk is freely supplied with communications from members of the Association relating to questions of policy, containing suggestions, and not infrequently urging modifications or elimination of existing conditions which in the opinion of the writers are imperative; he is constantly consulted by those who are interested in the improvements in medical education in all its departments, and by those who are concerned with the problems of public health, trained nursing, scientific advancement, and pending legislation related to medical matters; he is questioned almost invariably about the reports on so-called "cures," and on medical and surgical discoveries, which dot the pages of the public prints, and he is well-nigh compelled to disconnect his telephone from the newspaper offices of his immediate vicinity; he is asked insistently to contribute articles to various journals on all subjects ranging from those strictly related to medicine and surgery, general and special, to those which are published in the interests of public health, sanitary science, etc. These, briefly summarized, are some of the activities at his disposal; he may make his audience large or small. His is an active, responsible, stimulating, highly interesting job which any one, with all due humility, may be proud to hold.

These being some of the unbarred fields of opportunity, it may seem that no further comment is necessary. But I cannot refrain from stating an impression gained during the last two years that it would be advantageous should the duties of the President-Elect and President be more strictly defined in three respects:

1. That he shall attend the meetings of the Board of Trustees and those of its Executive Committees.

2. That he shall submit at stated intervals a report of his impressions and recommendations, which shall be published in the BULLETIN in order to attract approval, comment or criticism from our membership, as the case may be.

3. That he shall during the year of his service visit various portions of the country, properly and geographically selected, and shall be, subject to their approval, in attendance at the state or county meetings, prepared to receive suggestions and to discuss the activities of the Central Offices and the medical problems of the area visited, thus gathering the material for the report referred to. It is, of course evident that in the main this is exactly what is being done and doubtless will continue to be done. The only object of the suggestion is that opportunities may become duties, that responsibilities are enhanced—in short, that activities bear an official stamp. It may further be objected that such visits to various portions of the country, if acceptable to the societies there organized, are a function of the Field Secretary. But it has so happened during the past year that the Field Secretary and the President have met at one and the same meeting, and each has found a share of work which in no wise conflicted or introduced repetitions.

THE LEGAL BUREAU

The Legal Bureau, established within the last year, has demonstrated its value and importance. The record of its accomplished Executive Secretary is one of which we may well be proud. But much of that which he has accomplished is not written into that record. His quiet and unpublished assistance in time of legal need has been of real value. In my own state his keen analysis and criticism of pending medical legislation, which filtered through my office and was utilized as an argument before a committee of the house, was potent in helping to defeat at least one vicious bill. This department deserves the fullest measure of confidence and support.

If I may judge from the evidence available in my own vicinity, our hopes of the success of HYGEIA are realized, and I permit myself the pleasure of conveying my sincere congratulations, in which I feel sure all of you join, to the editors of this publication.

THE SECRETARY

Last August the Association sustained a grievous loss in the death of Dr. Alexander Craig. Representing the Association, I attended the funeral ceremonies, and it was a solemn privilege to tell individually his sorrowing relatives and neighbors of the high estimation in which he was held by his associates in the Central Offices, and by our membership. He worked faithfully, intelligently, admirably, with a brave and willing heart; he never forgot in all the manifold duties of his office the conduct of the higher life.

His place was not easy to fill; we are fortunate in the choice which was made. The Secretary's report attests the quality of his work and the excellence of his administrative ability. Often burdened with double and difficult duties, he has successfully met his obligations. Let us hope that in the near future we may find one who shall fill the greatly needed office of Field Secretary, and carry on the work which Dr. West so well inaugurated.

Of the various Councils, to which we are so largely indebted, I have spoken in addresses delivered in St. Louis last year, and I only pause to ask them, their chairman and their personnel, to accept my congratulations on their achievements.

THE JOURNAL

Of THE JOURNAL it is not necessary to speak in any detail. Not only we, and by this I mean American physicians, but physicians all over the world, are the beneficiaries of its distinguished editorial management and the excellence of its contents.

MEDICAL AID IN RUSSIA

As all here present know, the appeal for medical aid for Russia has attracted a large measure of sympathetic, as well as practical, attention. From a number of the prominent members of our Association, who belong to the Physicians'

and Surgeons' Committee which has been formed to further this worthy object. letters have been received, requesting that some action with respect to this work shall be taken by the House of Delegates. It would be of material assistance to them if a committee should be appointed to cooperate with them in different parts of the country in the collection of books, medical journals, instruments, clothing, etc., for the use of our suffering colleagues in Russia. I therefore suggest that this matter shall receive prompt consideration, and hope the House of Delegates will comply with the earnest request of our confrères as it is now presented.

Mr. Speaker and Members of the House of Delegates, two years ago you bestowed on me the greatest honor of my life. Untrained in the larger problems of administrative work, conscious of professional limitations, and always fully realizing the responsibilities imposed by this important office, I have endeavored to render the best service in my capacity. You have been gentle in your judgments; you and all the members of our Association have granted me a cordial reception; you have given help when it was needed; you have been uniformly courteous. I thank you from the bottom of my heart. At this hour of parting I say "good-bye" because I want you to accept these words in the full meaning of old Elizabethan valediction, and wish you and yours an abundant success in all your endeavors.

Remarks of President-Elect Dr. Ray Lyman Wilbur

The President-Elect, Dr. Ray Lyman Wilbur, California, addressed the House of Delegates extemporaneously. His remarks were referred to the Reference Committee on Reports of Officers.

Mr. Speaker and Members of the House of Delegates:

Since I am to have the opportunity of addressing the Association tomorrow night, I decided not to present a formal address this morning. I want, however, to bring before you a few points that occur to me in connection with this great Association.

I am the baby of the family, and the baby, you know, the beginner, has a right to talk, and if necessary, to be suppressed.

THE HOUSE OF DELEGATES

This Association is a very interesting and remarkable organizations. In some ways, it reminds me of Topsy; it has just grown up in a certain direction. It is an attempt in a great republic to get a form of representative government for the physicians of the country. It has various methods of doing its work. I will admit that it needs certain changes and certain revisions. This House of Delegates should be, as it is, a great policy-making body. I think sometimes it acts as an administrative body. No legislative body can do efficient work without an effective organization.

THE BOARD OF TRUSTEES

I have gone to the meetings of the Board of Trustees. They are a splendid group of men. It has been my fortune and misfortune sometimes to deal with a number of boards of trustees of all sorts, and I can say quite frankly that the Board of Trustees of the American Medical Association is just as good as any board of trustees in the country, but it is largely a custodial body. It does the custodial side of its work admirably.

A BOARD OF STRATEGY

What this organization needs is the thing Dr. Simmons has given it as an individual because of his peculiar position, and that is a board of strategy. It needs an administration that looks five or ten years ahead. We are plunging right along as a great medical body into all sorts of problems and difficulties. The Board of Trustees is meeting many of these problems.

There has been a discussion of having a member in the President's cabinet of Public Welfare. You cannot run a university unless there is some one who is thinking five or ten years ahead. That is my position as president of a university. I am supposed to be looking ahead all the time. You must get a board or some one of that type for this organization.

Scientific medicine is moving ahead so rapidly that in many ways we have left the people far behind and also some members of our own profession. We are mixed up in every one of the forty-one different states with legislatures and boards of health. The Speaker has referred to the need of getting our policies in such condition as to stand together, and in doing that we should realize, as a national organization, that we have to expect each state organization to work out its own policy.

DECENTRALIZATION

In the war, Washington became too prominent in this country's affairs. Every governor and every legislature looked to Washington during that time. That is a weakness. We must get decentralization of organization to force responsibility on the state organization, so that it will take the initiative in meeting its local conditions. It is a great problem in organization to get men at headquarters so that there is good management and wise provision for the future, so that each state may get the benefit of all information that comes in at headquarters, and that each state, as far as possible, be left to work out its own problems, and in its own way. This can be done. If you should make the present Board of Trustees such a board of strategy as I have outlined, they can carry this movement forward.

Some group of men must be thinking of what is going to happen to medicine in this country five, fifteen or twenty years from now.

What are the conditions under which medical students will be practicing fifteen or twenty years from now, and what is the Association to lay down as a groundwork so that the profession can go on with increasing opportunities, increasing responsibility and increasing service? It is a great task. It requires a great deal of thought, but it can be done.

One of the greatest functions of this Association has been the education of the medical profession through meetings like this, through publications such as THE JOURNAL. I wonder how many of you realize the enormous influence THE JOURNAL has exerted on medical education. Every physician has to learn something daily or he is going backward.

THE JOURNAL

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, under the leadership of its Editor and General Manager, has been a source of inspiration and direction for the members of the profession. Every man in the profession has had not only to get scientific training through THE JOURNAL but also a certain amount of technical training, and has had the opportunity to become informed as to what is going on in medical education and legislation, and the job has been so well done that we have accepted it. It is going to be a great task to work out the different problems in the years to come, and it will require great thought on your part if we are going to do as much for the profession in the future as we have done in the past. Think for a moment of the problem of the man who is on what we might call the borderline of medical practice, serving the public somewhat more than he is any individual patient. Think of the attitude of the public toward him, and realize that this is the element that is growing in medical practice. There is less service to the individual by the profession and more service to the public, and the public is being served through the individual more than ever before, and it requires many points of view to bring about a satisfactory division of public relationships under these conditions. It can be done, but it cannot be done unless we are willing to think it out thoroughly and unless we are looking ahead.

THE SCIENTIFIC SECTIONS

The most striking thing about this organization to me is the scientific sections. If you will study the organizations of these sections and look over the types of papers that are read, you can see great prospects in the development of American medicine. The real strength of the organization lies in its sections, and they are vital forces to the organization.

If there is anything in this whole scheme, it should be one of harmony of all the policies that go to make up medical progress viewed in its broadest sense. Such an organization as this, while it must devote major thought to

the major part, must never forget the others. We must look out for the general practitioners; but if we should look out for them alone, we would lose one of the great functions of this organization, which is to get the best thoughts of those in medicine, and bring them within our door. That has been done up to date.

PERIODIC PHYSICAL EXAMINATION

There are a number of other points I have been requested to bring to your attention, two in particular. One, is the increasing interest throughout the country for some form of periodic physical examination. This, if carried out, will afford the greatest possible opportunity of scientific medicine. It is a sad thing when a man wants to know where he stands in the world, and comes for an examination and is not given a thorough examination, but is laughed at, and the doctor tells him, "You are all right"; "don't come for an examination unless you are mighty sick or have a temperature of 105." Physicians ought not to take such an attitude, although it is the attitude that modern medicine takes in regard to the normal man and serves to isolate him against the diseases of his body. The physician should study biologic reactions of the man and help him to meet the problems that come to him in the way of disease. The physician should have a record of how the man stands when he first sees him, and compare that record with his condition six months hence; then he has something to stand by. If we could get that carried out through intellectual groups we would do more good than all the cults and faddists. There is no doubt in my mind that this is one great weakness. We are trained to think in terms of disease, and we must now turn our attention to thinking in terms of being well; when we do, the people will rally to us in a new way.

RUSSIAN RELIEF

President de Schweinitz referred to the Russian relief. This is an interesting and tangled problem. Out of all that terrible mess in Russia one thing stands out very prominently. The physician, although he has submitted to great hardships, for the most part, has been allowed to survive in the various communities, while the other men with brains were eliminated in one way or another. The physicians over there are the one germ of a new civilization in many communities. If there is anything we can do to help these men we ought to do it, but we must be sure to help them and not simply help some government organization. If this great Association can work out a device that will bring real assistance, books, instruments and drugs into the hands of Russian physicians, it will accomplish a great amount of good.

As you probably know, the American Relief Administration has done in Russia probably the largest piece of work done in this century. It has inoculated six million people against three or four diseases. We have already taken an active part in protecting the population. If we can find some means to protect the profession and let medicine serve as the germinating focus for a new Russia, and it can be done, it will be a great service on the part of this Association.

I have spoken to you somewhat briefly on some of the points that have occurred to me in regard to this great organization. I believe in plain speaking. I am going to try to serve you in every way I can. I want your personal individual help. I want you all to feel that if you see any way by which you can make me more effective as President of the Association, do not hesitate to do so. If I do not agree with you, you will find it out. I am perfectly willing to do anything I can to further the objects of this Association. There is not anything more worth while in this country. You men have a great opportunity. Medicine stands right at the top of the intellectual levels of this country. Medicine requires more in the way of training of our young men than any other profession. We are getting a better personnel. If you take the intelligence tests of the successful medical students, you will realize that we are getting a high grade group of men, who are going to come along as our followers. Anything we can do as individuals or as an Association, or anything I can do as President to make the conditions favorable for them in the future so that they serve their maximum duty, I will be happy to do.

Again, I want to thank you for the great honor of being elected President of this Association. It is a particular privilege to follow such a splendid man as President de Schweinitz.

Reference Committees

The speaker announced the following Reference Committees:

LEGISLATION AND PUBLIC RELATIONS

Holman Taylor, Chairman.....Texas
J. D. Brook.....Michigan
C. E. Humiston.....Illinois
H. M. Brown.....Wisconsin
W. R. Steiner.....Connecticut

HYGIENE AND PUBLIC HEALTH

J. A. Pettit, Chairman.....Oregon
B. L. Bryant.....Maine
William R. Bathurst.....Arkansas
Walter F. Donaldson.....Pensylvania
C. J. Whalen.....Illinois

CONSTITUTION AND BY-LAWS

William Gerry Morgan, Chairman.....District of Columbia
E. H. Cary.....Texas
E. A. Hines.....South Carolina
W. H. Mayer.....Pennsylvania
E. L. Hunt.....New York

CREDENTIALS

B. R. McLellan, Chairman.....Ohio
Horace J. Brown.....Nevada
E. A. Pray.....North Dakota
C. T. Pigot.....Montana
G. P. Johnston.....Wyoming

MISCELLANEOUS BUSINESS

Southgate Leigh, Chairman.....Virginia
W. H. Seeman.....Louisiana
Henry Boswell.....Mississippi
A. D. Dunn.....Nebraska
J. W. Flinn.....Arizona

REPORTS OF OFFICERS

E. Eliot Harris, Chairman.....New York
A. W. Hornbogen.....Michigan
H. A. Royster.....North Carolina
D. E. McGillivray.....Washington
W. D. Haines.....Ohio

SECTIONS AND SECTION WORK

A. E. Bulson, Jr., Chairman.....Indiana
C. E. Mongan.....Massachusetts
L. H. McKinnie.....Colorado
A. W. Booth.....New York
Philip Marvel.....New Jersey

RULES AND ORDER OF BUSINESS

H. P. Linsz, Chairman.....West Virginia
J. W. Bell.....Minnesota
W. H. Block.....Louisiana
L. L. Sheddan.....Tennessee
S. W. Welch.....Alabama

MEDICAL EDUCATION

F. B. Lund, Chairman.....Massachusetts
Frederick Epplen.....Washington
Randolph Winslow.....Maryland
Cornelius Van Zwalenburg.....California
W. Albert Cook.....Oklahoma

Report of Secretary

The Secretary presented his report, which was referred to the Reference Committee on Reports of Officers, with the exception of that part of the report which refers to a change in the name of the Council on Medical Education and Hospitals, which was referred to the Reference Committee on Amendments to the Constitution and By-Laws. (See page 1911, last week.)

The communication from Dr. J. R. McDill, United States Veterans' Bureau (p. 1914) was referred to the Board of Trustees.

Dr. Joseph A. Pettit, Oregon, moved that all further reports of standing and special committees be presented in abstract form.

Seconded and carried.

Report of Board of Trustees

Dr. Oscar Dowling, Louisiana, Chairman, presented the Report of the Board of Trustees, which was referred to the Reference Committee on Reports of Officers. (See page 1915, last week.)

In addition, Dr. Dowling presented the following communication from Dr. Charles E. Sawyer, Brig. Gen., M. R. C.:

WAR DEPARTMENT
Washington

May 4, 1923

Board of Trustees,
American Medical Association,
535 N. Dearborn Street,
Chicago, Illinoids.

Gentlemen:

Unless the committee appointed at the Boston meeting of the American Medical Association is active and prepared to cooperate in matters pertaining to the institution of a Department of Welfare in the Government, it seems to me proper that a new committee be appointed at your San Francisco meeting to take up this matter as now contemplated at such time as it may be deemed proper to do so.

If agreeable, I would be pleased to have you name such men as understand the objects and purposes, who can find it consistent and convenient to meet early in the autumn, before Congress convenes again, to discuss ways and means whereby the subject can be handled in the best possible way.

Very truly yours,

C. E. SAWYER,
Brig. Gen., M. R. C.

This communication was referred to the Reference Committee on Reports of Officers.

Report of the Judicial Council

Dr. M. L. Harris, Illinois, Chairman, requested that the report of the Judicial Council be referred to the Reference Committee on Amendments to the Constitution and By-Laws, without being read, and it was so ordered. (See page 1925, last week.)

Report of the Council on Health and Public Instruction

In the absence of Dr. Victor C. Vaughan, Chairman of the Council on Health and Public Instruction, the report was presented by Dr. Haven Emerson, a member of the Council. The Report was referred to the Reference Commitee on Hygiene and Public Health. (See page 1926, last week.)

Report of the Council on Medical Education and Hospitals

In the absence of Dr. Arthur D. Bevan, Illinois, Chairman of the Council on Medical Education and Hospitals, the report was presented by the Secretary of the Council, Dr. N. P. Colwell, and was referred to the Reference Committee on Medical Education. (See page 1928, last week.)

Report of the Council on Scientific Assembly

Dr. J. Shelton Horsley, Virginia, Chairman, read the Report of the Council on Scientific Assembly, which was referred to the Reference Committee on Sections and Section Work. (See page 1937, last week.)

Report of Committee on District Division

Dr. L. H. McKinnie, Colorado, Chairman, presented the report of the Special Committee on District Division, which was referred to the Reference Committee on Miscellaneous Business. (See Association News, THE JOURNAL, April 21, 1923, p. 1149.)

Next Meeting Place

The Secretary presented invitations to hold the next annual session of the Association in Chicago, Atlantic City and Oklahoma City.

Report of Bureau of Legal Medicine and Legislation

At the request of the Board of Trustees, Dr. William C. Woodward, Executive Secretary, presented the report of the Bureau of Legal Medicine and Legislation, which was referred to the Reference Committee on Reports of Officers. (See page 1921, last week.)

Resolution on Labeling of Lye and Corrosive Acids

Dr. Burt R. Shurly, Michigan, delegate from the Section on Laryngology, Otology and Rhinology, presented the following resolutions, which were referred to the Reference Committee on Hygiene and Public Health:

WHEREAS, The domestic use of concentrated lye and other caustic alkalis and of corrosive acids, in ignorance of their dangerous properties and of treatment in case of accident, is a not infrequent cause of death and of prolonged, distressing and incurable disability, particularly among children; and

WHEREAS, In the judgment of this House, the adoption of suitable methods of packing, labeling and distributing such substances would materially diminish the danger; and

WHEREAS, Efforts to bring about the adoption of such methods by the voluntary action of manufacturers and distributors has given no prospect of success, be it

Resolved, That it is the sense of the House of Delegates of the American Medical Association, in convention assembled, that in the interest of public health and safety the packing, labeling and distribution of concentrated lye and of other caustic alkalis and of corrosive acids should be regulated by law; and be it further

Resolved, That the Board of Trustees be instructed to take such action as may be necessary to procure the enactment of such federal and state laws as may be necessary to effect such regulation.

Resolution on Death of Dr. Craig

Dr. Arthur T. McCormack, Kentucky, moved that when the House of Delegates adjourn, it do so in honor of the memory of the late Dr. Alexander R. Craig.

Seconded and carried.

Resolution on Chemical Laboratories

Dr. John W. Kerr, from the United States Public Health Service, presented the following resolution at the request of the Secretary of the American Chemical Society, which was referred to the Reference Committee on Miscellaneous Business:

WHEREAS, Measures for the control of clinical laboratories have been introduced in the legislatures of certain states, and

WHEREAS, This form of legislation affects the interests of physicians, chemists, bacteriologists and pathologists; therefore, be it

Resolved, That the House of Delegates authorize the President to appoint a committee to confer with representatives of the American Chemical Society, and the Society of Bacteriologists and Pathologists regarding this matter and report back one year hence with such recommendations as may be pertinent; provided in the interim the Board of Trustees, cooperating with the committee, takes such action as may be necessary to protect the interests of the profession and the public.

Amendment to By-Laws Covering Council on Health and Public Instruction

Dr. Joseph W. Pettit, Oregon, presented a proposed amendment to the By-Laws, to relieve the Council on Health and Public Instruction of responsibility for legislation, the responsibility therefor having been transferred to the Bureau of Legal Medicine and Legislation, acting under direction of the Board of Trustees, by resolution adopted by the House of Delegates, May 23, 1922. It was referred to the Reference Committee on Amendments to the Constitution and By-Laws. The proposed amendment was as follows:

WHEREAS, The Board of Trustees was authorized by resolution adopted by the House of Delegates, May 23, 1922, to establish a central bureau for the consideration of all legislative matters pertaining to medicine or the practice of medicine and to the public health; one purpose of which was to relieve the Council on Health and Public Instruction of such duties;

Resolved, That the By-Laws, Chapter IX, entitled "Duties of Standing Committees or Councils," Section 2, be amended by striking out the words and number, "Legislation. (2)," and renumbering the following two phrases, so that said section will read: "Section 2. Council on Health and Public Instruction—The functions of the Council on Health and Public Instruction shall embrace the following subjects: (1) Public Instruction. (2) Defense of Medical Research. (3) Public Health."

Resolutions on Regulation of Alcohol

Dr. Charles O'Donovan, Maryland, presented the following resolutions, which were referred to the Reference Committee on Legislation and Public Relations:

President
Dr. Herbert Harlan
Secretary,
J. Albert Chatard, M.D.
Treasurer,
Charles Emil Brack, M.D.

Medical and Chirurgical Faculty of the State of Maryland,
1211 Cathedral Street,
Baltimore.

June 6th, 1923.

Dr. Olin West, Secretary,
American Medical Association,
Chicago, Illinois.

My dear Dr. West:

The following resolution was adopted at the Annual Meeting of this Association, held April 25th, and our delegates instructed to present the same.

Resolved, By the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland at its Annual Meeting, in Baltimore,

April 25th, 1923, That the present method of obtaining alcoholic stimulants as a medicine by physician's prescriptions is an intolerable nuisance to doctor and patient alike; and be it also

Resolved, That the Faculty again urges the American Medical Association to make every effort to have removed this detestable restriction upon the practice of medicine; and be it also

Resolved, That these resolutions be presented to the American Medical Association by our delegates to the approaching meeting in San Francisco.

J. ALBERT CHATARD, Secretary.

Communication from Philadelphia Pediatric Society on Advertising of Infant Foods

The Secretary read the following communication from the Philadelphia Pediatric Society, which was referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, The American Medical Association is publishing a journal for the laity, called *Hygeia*, and

WHEREAS, Said journal contains advertisements of several infant foods, and

WHEREAS, The appearance of said advertisements, in the eyes of the public, definitely implies recommendation by the members of the American Medical Association of these infant foods, and

WHEREAS, The recommendation of said foods will tend to undo all the work which thousands of the members of the medical profession have been trying to accomplish in the education of the public to the fact that infants cannot be fed in this indiscriminate manner, and

WHEREAS, The Philadelphia Pediatric Society, since its foundation in 1896, has been endeavoring to foster scientific infant feeding, therefore be it

Resolved, That the Philadelphia Pediatric Society voices its most earnest protest to the appearance of infant food advertisements in the journal called *Hygeia*, and, further be it

Resolved, That the secretary of said Society be instructed to transmit these resolutions to the President and to the House of Delegates of the American Medical Association, to the President and Secretary of the Pennsylvania State Medical Society, and to the Board of Directors of the Philadelphia County Medical Society, and to such other societies as the President and Secretary shall urge to cooperate.

Communication on Russian Relief

The Secretary presented the following communication from Dr. John Ruhrāh, Maryland, which was referred to the Board of Trustees:

June 11, 1923.

Dr. Olin West,
535 North Dearborn St., Chicago, Illinois.

Dear Dr. West:

It will certainly not be necessary to say anything about the importance of the work of the medical section of the American Friends Service Committee, furnishing American medical aid for Russia. As a member of the local committee in Baltimore may I urge you to see that the appeal for relief of Russian physicians is adequately presented at the meeting of the American Medical Association and also that the House of Delegates is asked to have appointed a committee to cooperate with the existing organization.

JOHN RUHRĀH.

Adjournment

Dr. Thomas Clark Chalmers, New York, moved that the House of Delegates adjourn until 3 p. m., and that the first order of business of the afternoon be New Business.

Motion seconded, and on being put to a vote was declared lost.

On motion of Dr. Arthur J. Bedell, New York, which was duty seconded, the House of Delegates then adjourned to meet at 9:30 a. m., Tuesday.

Second Meeting—Tuesday Morning, June 26

The House of Delegates met at 9:30 a. m., and was called to order by the Speaker.

Roll call being the first order of business, the Secretary stated that he had registered slips of considerably more than a quorum, and moved that the roll call be made up from these slips.

Seconded and carried.

The minutes of the previous meeting were read and approved.

Dr. B. R. McClellan, Ohio, Chairman, made a supplementary report for the Committee on Credentials, stating that ten additional delegates had registered, making a total of 129 delegates.

As there were no objections, the supplementary report of the committee was accepted and filed.

The Speaker announced Dr. W. Albert Cook, Oklahoma, as a member of the Reference Committee on Medical Education.

Recommendation on National Educational Association

Dr. Haven Emerson, New York, presented the following recommendation of the Council on Health and Public Instruction to the House of Delegates of the American Medical Association, which was referred to the Reference Committee on Hygiene and Public Health:

In 1911, the American Medical Association, meeting at Los Angeles, California, appointed a committee to visit the meeting of the National Education Association which met the following week in San Francisco. The committee was instructed to convey greetings from the A. M. A. to this great national association of teachers, and also to call to their attention the importance of health in education.

The response to this suggestion on the part of the National Education Association was very prompt and gratifying. A strong committee of twelve of the leading educators of the United States was appointed to serve as a committee on the health problems in education and to cooperate with a committee of the A. M. A.

Throughout the succeeding twelve years, this joint committee has been engaged in a study of these problems and has accomplished noteworthy results in their solution. The cordial cooperative spirit of the National Education Association has been most gratifying.

It seems fitting that the American Medical Association should express its appreciation of the hearty, effective response to the suggestion made in 1911. Be it therefore

Resolved, That a committee be appointed by the President of the American Medical Association to attend the annual meeting of the National Education Association to be held in Oakland, California, July 1-5, to again convey greetings and good wishes to that organization and to express the appreciation of the American Medical Association for the splendid work which has been accomplished in the matter of emphasizing the importance of health and all that makes for health in the conduct of our schools.

Reference Committee on Medical Education

Dr. F. B. Lund, Massachusetts, Chairman, presented the report of the Reference Committee on Medical Education and Hospitals, as follows:

SHORTAGE OF PHYSICIANS

Your committee notes with approval the general improvement in undergraduate medical schools. The steady increase in the number of students in the medical colleges is an indication that there will be no such shortage of physicians in the community as has been so freely predicted. The present so-called shortage is perhaps largely a question of distribution. It is also gratifying to note that the age of graduates has not been materially increased with the increase of the requirements for admission.

THE MEDICAL CURRICULUM

The vexed question of the medical curriculum is not yet settled and probably never will be, but a definite improvement is noted in the increasing correlation between laboratory and clinical teaching. The close association of laboratory and clinical plants is a matter of the first importance. The committee is pleased to note that the general practitioner is not going to be entirely relegated to obscurity, since it is the opinion of the Council that so large a proportion as from 80 to 90 per cent. of the cases can be properly cared for by a well-qualified general practitioner, and 90 per cent. can be cared for in their homes. The comfort and convenience of hospitals and their inestimable advantages in certain classes of cases should not, however, be forgotten.

GROUP CLINICS

In regard to group clinics, it is evident from the report that the term is very loosely applied. In the judgment of the committee the necessities of the situation—at least in large communities—will largely prevent close and iron-clad group association. Patients will, to a certain extent, choose their own surgeons and physicians who may be outside the group to which they first apply. On the other hand, group practice tends to prevent the undertaking by certain men of tasks which they are unfitted to perform, and is an excellent thing if carried out on a broad ethical basis.

RURAL COMMUNITIES

In regard to the important subject of adequate medical service for rural communities, the committee feels that the suggestion of a guaranteed salary is an excellent one, and perhaps the only one that promises a solution of the problem. Improved transportation and the telephone have already done much to solve the problem from the point of view of the patient.

We note with interest the important work of the Council in collecting and publishing information regarding hospitals. The committee feels that the development of community hospitals will help to solve the problem, in rural districts not adequately served by hospitals in near-by cities.

DISPENSARY ABUSE

The evidence that the abuse of hospitals and dispensaries by patients that can afford to pay is kept at a minimum is noted with approval, but the committee feels that there is still a deplorable amount of medical pauperization, which can be controlled only by centralization of effort and by eternal vigilance. The cooperation of social service workers toward economy, rather than toward the increase in size of the clinic, is desirable.

THE TRAINED NURSE

The vexed question of the trained nurse has been carefully and adequately dealt with by your Council: The education and training of the nurse should not be so expensive in time and money as to place her services beyond the reach of the average family. Primarily she is and should remain a trained lieutenant of the physician. The recommendations of the council that the nursing question be referred to a joint committee of physicians and nurses is heartily approved. We also approve the personnel of the committee as named in the report of the council, and recommend that the gentlemen named be designated for this duty. As suggested by the council, the secretary of the council ought to serve as secretary of the committee.

GRADUATE TRAINING

Improvement in graduate medical training is greatly to be desired. The principles enunciated by the Council in its report are endorsed by your committee, which recommends that the list of approved institutions be published. Diplomas or certificates granted by schools for graduates, after one to six weeks of attendance, ought to be eliminated. The value of legitimate certificates will be established in case the recommendations of the council are carried out.

The work of the Council as a whole is approved, and the committee feels that its recommendations in regard to graduate medical education will mark an epoch of perhaps no less importance than that in undergraduate education begun in 1904.

RANDOLPH WINSLOW
CORNELIUS VAN ZWALENBURG
FREDERICK EPPLEN
FRED B. LUND

Dr. Arthur T. McCormack, Kentucky, moved that the report be adopted as read.

Seconded and carried.

The list of approved graduate medical schools referred to in the report of the Reference Committee on Medical Education is as follows:

APPROVED GRADUATE MEDICAL SCHOOLS

On the basis of three complete inspections of the graduate medical schools and the schedule of principles just outlined, the following list of approved graduate (or postgraduate) medical schools has been prepared:

THOSE GIVING SATISFACTORY GENERAL PRACTICE COURSES, OR COMPLETE COURSES IN ONE OR MORE SPECIALTIES

Harvard Medical School, Boston.—Basic Review and General Practice Courses.
Johns Hopkins Medical School, Baltimore.—Special Residencies in the Johns Hopkins Hospital and General Practice Courses.
Massachusetts Charitable Eye and Ear Infirmary, Boston.—Special Internships in Eye, and in Ear, Nose and Throat.
Manhattan Eye, Ear and Throat Hospital School of Graduate Medical Instruction, New York.—Special Internships in Eye, and in Ear, Nose and Throat.
New York Eye and Ear Infirmary, Graduate School of Ophthalmology and Otology, New York.—Special Internships in Eye and in Ear.
New York Post-Graduate Medical School, New York.—Special Internships and General Practice Courses.
Tulane University, New Orleans.—Higher Degree and General Practice Courses.
University and Bellevue Hospital Medical College, New York.—Special Course in Surgery.
University of California, Berkeley-San Francisco.—Higher Degree Courses.
University of Minnesota Graduate School of Medicine, Minneapolis-Rochester. — Higher Degree Fellowships and General Practice Courses.
University of Pennsylvania Graduate School of Medicine, Philadelphia. —Higher Degree and General Practice Courses.

Also, acceptable rules or other satisfactory arrangements for higher degree or general practice courses have been inaugurated or adopted by the following university medical schools:

THOSE HAVING GRADUATE SCHOOLS, OR COURSES IN PROCESS OF DEVELOPMENT

Columbia University College of Physicians and Surgeons, New York. —Higher Degree and General Practice Courses.
Cornell University Medical College, New York.—Higher Degree and General Practice Courses.
University of Chicago, Rush Medical College, Chicago. — Special Courses in Eye, in Ear and General Practice and Higher Degree Courses.
University of Illinois College of Medicine, Chicago.—Higher Degree Courses in Preclinical Branches.

FUTURE ADDITIONS TO LIST

This report does not rule out any graduate medical school. Other institutions which are offering higher degree opportunities in medical subjects, other hospitals with special residencies, and other graduate medical schools will be added to the list on application and after, on investigation, their educational standards and provisions for postgraduate education are found to be satisfactory.

Reference Committee on Hygiene and Public Health

Dr. Joseph A. Pettit, Oregon, Chairman, presented the report of the Reference Committee on Hygiene and Public Health as follows:

The Reference Committee on Hygiene and Public Health recommends the passage of the following resolution regarding the packing, labeling and distribution of concentrated lye and other caustic alkalis, and of corrosive acids, offered by Dr. Burt Shurly.

WHEREAS, The domestic use of concentrated lye and other caustic alkalis and of corrosive acids, in ignorance of their dangerous properties and of treatment in case of accident, is a not infrequent cause of death and of prolonged, distressing and incurable disability, particularly among children; and

WHEREAS, In the judgment of this House, the adoption of suitable methods of packing, labeling and distributing such substances would materially diminish the danger; and

WHEREAS, Effects to bring about the adoption of such methods by the voluntary action of manufacturers and distributors have given no prospect of success, be it

Resolved, That it is the sense of the House of Delegates of the American Medical Association, in convention assembled, that in the interest of public health and safety the packing, labeling and distribution of concentrated lye and of other caustic alkalis and of corrosive acids should be regulated by law; and be it

Resolved, Further, that the Board of Trustees be instructed to take such action as may be necessary to procure the enactment of such federal and state laws as may be necessary to effect such regulation.

The Reference Committee on Hygiene and Public Health recommends the passage of the resolution by the House of Delegates, that the Council on Health and Public Instruction be requested to prepare a plan for participation by the American Medical Association in exhibits, organized for instruction of the public in health and medical services, when such exhibits are inaugurated or inaugurated or approved by a state or county medical society.

The Reference Committee on Hygiene and Public Health recommends the passage of the resolution that the Council on Health and Public Instruction be directed to initiate and carry out an intensive campaign of education of physicians in the necessity and method of conducting thorough and accurate medical examinations of apparently healthy persons, through the agency of State and County Medical Societies, Hospitals, and Medical Schools.

The Reference Committee on Hygiene and Public Health recommends the adoption of the report of the Council on Health and Public Instruction, excepting the first paragraph, page 88.

JOSEPH A. PETTIT, Chairman.

The report was considered, section by section, and on several motions, which were duly seconded, the report was adopted.

Report of Reference Committee on Amendments to Constitution and By-Laws

Dr. William Gerry Morgan, District of Columbia, Chairman, presented the report of the Reference Committee on Amendments to the Constitution and By-Laws, as follows:

Your Reference Committee on Amendments to the Constitution and By-Laws begs to make the following report:

1. Your committee recommends that, at the request of Dr. Mongan, his resolution to amend Article 5, Sections 2 and 3, of the Constitution, be laid on the table.

2. Your committee recommends that at the request of Dr. Mongan his resolution to amend Article 7 of the Constitution be laid on the table.

3. The action of Dr. Mongan in requesting that these resolutions to amend the Constitution be laid on the table automatically removes consideration of his resolution to amend the By-Laws.

4. Your committee recommends that at the request of Dr. Upham his resolution to amend Article 5, Sections 2 and 3, of the Constitution be laid on the table.

This action on the part of Drs. Mongan and Upham meets with the approval of your committee because your committee would look with disfavor on any amendments to the Constitution which would abridge the present representation in the House of Delegates. Therefore, your committee recommends that the resolutions be laid on the table.

5. Your committee recommends that the report of the Reference Committee on Medical Education, which report recommends changing the name of the Council on Medical Education and Hospitals to that of the Council on Education and Hospitals of the American Medical Association be not adopted.

WILLIAM GERRY MORGAN, Chairman,
EDWARD H. CARY,
EDGAR A. HINES,
WILLIAM H. MAYER,
EDWARD LIVINGSTON HUNT, Secretary.

The report was considered section by section. Regarding the first section of the report, Dr. J. W. Van Derslice, Illinois, moved that the consent of the House of Delegates be given to Drs. Mongan and Upham to withdraw their proposed amendments.

Seconded and carried.

Accordingly, the proposed amendments were withdrawn.

AMENDMENT TO THE BY-LAWS, TO RELIEVE THE COUNCIL ON HEALTH AND PUBLIC INSTRUCTION OF RESPONSIBILITY FOR LEGISLATION, THE RESPONSIBILITY THEREFOR HAVING BEEN TRANSFERRED TO THE BUREAU OF LEGAL MEDICINE AND LEGISLATION, ACTING UNDER DIRECTION OF THE BOARD OF TRUSTEES, BY RESOLUTION ADOPTED BY THE HOUSE OF DELEGATES, MAY 23, 1922.

WHEREAS, The Board of Trustees was authorized by resolution adopted by the House of Delegates, May 23, 1922, to establish a central bureau for the consideration of all legislative matters pertaining to medicine or the practice of medicine and to the public health, one purpose of which was to relieve the Council on Health and Public Instruction of such duties:

Resolved, That the By-Laws, Chapter IX, entitled "Duties of Standing Committees or Councils," Section 2, be amended by striking out the words and number, "Legislation. (2)," and renumbering the following two phrases, so that said section will read: "Section 2. Council on Health and Public Instruction.—The functions of the Council on Health and Public Instruction shall embrace the following subjects: (1) Public Instruction. (2) Defense of Medical Research. (3) Public Health."

Your committee recommends that this resolution be adopted.

PROPOSED AMENDMENT TO THE CONSTITUTION, TO EXTEND THE TERM OF THE TRUSTEES TO FIVE YEARS, WITH THE PROVISO THAT NO TRUSTEE SHALL SERVE MORE THAN TWO CONSECUTIVE TERMS.

WHEREAS, A trustee, because of the multiplicity and complexity of the affairs which he must consider and act upon, can hardly attain a full measure of efficiency in so short a time as the period of service for which he is now elected, three years, at the expiration of which period, he may or may be reelected; and

WHEREAS, It is nevertheless desirable that there be no indefinite continuance of a trustee in office; be it

Resolved, That the Constitution, Article 6, entitled "General Officers." Section 2, be amended by striking out the words therein defining the terms of trustees, to wit, "three of whom shall be elected annually, each to serve three years," and by adding to the section thus amended, the following:

Two trustees shall be elected annually, except every fifth year, when but one shall be elected, each to serve five years and until his successor is elected and installed. No trustee shall serve for more than two consecutive terms, but a trustee elected to serve the balance of an unexpired term shall not be regarded as having served a term unless he has served three or more years: Provided, that at the session of the House of Delegates at which this amendment is adopted, two trustees shall be elected to serve three years and one to serve four years; at the next annual session thereafter, one to serve three years and two to serve four years; and at the next subsequent session, two to serve four years and one to serve five years; and thereafter every trustee shall be elected as heretofore directed.

Your committee recommends that this resolution be approved and laid on the table for one year in accordance with the Constitution.

WILLIAM GERRY MORGAN, Chairman,
WILLIAM H. MAYER,
EDWARD H. CARY,
EDGAR A. HINES,
EDWARD LIVINGSTON HUNT, Secretary.

Regarding that section of the report extending the term of the trustees to five years, the committee recommended that the resolution be approved and laid on the table for one year in accordance with the Constitution.

Dr. Holman Taylor, Texas, moved that the recommendation of the committee be adopted. Seconded.

Dr. W. H. Seeman, Louisiana, moved as a substitute that the recommendation of a change in the Constitution be laid over until next year.

Seconded and carried.

The report was further considered section by section, and each section adopted, after which Dr. Morgan moved the adoption of the report as a whole, which motion was duly seconded and carried.

Report of Reference Committee on Reports of Officers

The report of the Reference Committee on Reports of Officers was called for.

Dr. E. Elliott Harris, New York, Chairman, stated that the committee was able to make only a partial report of the matters referred to it at this time, and that Dr. Hubert A. Royster, North Carolina, a member of the committee, would present the report.

Dr. Royster stated that the committee had had referred to it for consideration the address of the Speaker, the President's address, the President-Elect's address, report of the Secretary, report of the Board of Trustees, the communication by Brigadier General Sawyer, etc.

1. Taking up these items seriatim, in regard to the address of the Speaker, after deliberation the committee believes that a midyear meeting of the House of Delegates is unpractical and offers as a suggestion that the House of Delegates meet annually four days before the scientific session.

2. Concerning the second recommendation, in regard to the enunciation as to the position taken by the scientific section, the committee called attention to Chapter XVI of the By-Laws, which reads: "No memorial, resolution or opinion of any character whatever shall be issued in the name of the American Medical Association unless it has been approved by the House of Delegates."

3. The committee joins the Speaker in his recommendation that a compilation of the policies of the Association be undertaken by the Secretary, and that a copy of this compilation be furnished to the secretaries of the constituent associations and to the delegates of the House of Delegates.

4. The committee concurs in the recommendation to appoint a special committee as named for the purpose of representing the Association at further conferences on the question of a National Welfare Department, and desires to emphasize that the particular object of this committee is to protect the interests of the medical profession and the public in such deliberations.

5. The committee agrees that in the urgency of war there was a demand for Red Cross aid for the relief of disease and accident, but that at the present time, when there is no such urgency, there is no need for the entrance of this organization into the field of medicine or community clinic activities.

Your committee voted unanimously that the Board of Trustees convey this recommendation of the Reference Committee to the officials of the Red Cross.

6. With reference to the training of full-time secretaries at the National Headquarters of the Association, your committee deems the recommendation inexpedient at the present time.

7. Your committee considers favorably the recommendations received from the delegates in response to the Speaker's inquiries and offers the following amendment to the By-Laws, Chapter 10, Section 1, as a substitute for the first sentence of this section:

The Speaker of the House of Delegates shall appoint from the members of the House, in advance of the annual meeting, such committees as he may deem expedient for the transaction of the business of the House of Delegates, thus giving an opportunity to appoint these committees before the rush.

8. Your committee wishes to state that the work imposed this year on the Reference Committee on Reports of Officers was sufficient to occupy more than a reasonable time of three reference committees.

At this juncture the Vice Speaker, Dr. Rock Sleyster, Wissonsin, took the Chair.

9. In regard to that part of the report of the Secretary concerning the BULLETIN, your committee believes that its publication should be continued, and that a copy of the same should be sent to every Fellow of the Association.

10. With reference to that part of the Secretary's report concerning the advisability of conferring authority on the councils of the constituent state associations for electing delegates and alternate delegates when those duly elected at the annual meeting cannot serve, your committee recommends that the matter be referred to the Reference Committee on Constitution and By-Laws.

Regarding the position of a field secretary, as recommended by the Speaker and Secretary, your committee recommends that it be referred to the Board of Trustees for action.

Dr. Harris moved the adoption of this part of the report.

Seconded and carried.

11. In regard to postgraduate courses of instruction in county medical societies, your committee suggests that feasible plans may be worked out, provided they are handled tactfully and in close cooperation with the state and county organizations. The committee recommends that the Council on Medical Education and Hospitals be authorized to act on this question.

12. Regarding the plan of organization, your committee believes that while the state societies in most instances should assume the initiative, particularly concerning the good of the profession in their respective states, it also realizes that in matters of large moment the parent organization must map out certain programs in cooperation with the constituent societies. Specifically, it should be understood that the nucleus of legislation starting in the state organizations should be supported by the American Medical Association. Where there is disagreement between the central organization and the constituent societies, the general officers of the parent organization should confer with the authorities of the state associations.

13. As to the importance of the office of councilor in state societies, as proposed by the Secretary, your committee approves and desires to stress their duties in the sphere of organization and under the direction of county and district societies.

14. Your committee recommends that the secretaries' conference be approved and continued and that the presidents and presidents-elect of state societies be invited to participate in these conferences.

15. Your committee recommends that the plan of having the Secretary reserve hotel accommodations for the official delegates be continued, and that the Secretary be instructed to hold these reservations until fifteen days before the time of the meeting.

16. In regard to that part of the President's address which refers to pregraduate and postgraduate medical education, your committee recommends that it be referred to the Council on Medical Education and Hospitals.

17. Regarding the second part of the report which relates to the business of the Association, your committee recommends that it be referred to the Board of Trustees.

18. In conclusion, your committee wshes to state that it greatly enjoys the vision of the future of medicine as presented by the President-Elect, as well as the terse diction which he employed in its expression.

Dr. S. W. Welch, Alabama, moved that the various items in the report be taken up section by section.

Seconded and carried.

Regarding Section 1, Dr. E. Eliot Harris, New York, moved that the suggestion of the Speaker be not acted on.

Seconded and carried.

In regard to Section 2, Dr. Harris stated that the Speaker had called attention to the inconsistency of various sections passing resolutions that were inconsistent with the policies declared by the House of Delegates, and said that no action need be taken on this because there is a by-law which states that no memorial, resolution or opinion of any character whatever shall be issued in the name of the American Medical Association unless it has been approved by the House of Delegates, and that therefore this part of the Speaker's address is covered in the By-Laws.

Relative to Section 3, concerning a compilation of the policies of the Association by the Secretary, Dr. Harris said that the Reference Committee found itself somewhat embarrassed in forming opinions and recommendations on reports of the various officers of the Association, because it did not have in its possession any of the previous resolutions pasesd by the House of Delegates relating to policies already discussed and adopted by the House. Accordingly, he moved that the recommendation giving the Secretary of the Association authority to make a compilation of the policies for the use of the Association be adopted.

Seconded and carried.

Regarding Section 4 of the report, concerning the appointment of a special committee for the purpose of representing the Association at future conferences on the question of a national welfare department for the protection of the interests of the medical profession and the public, Dr. Harris moved that the recommendation of the Speaker be concurred in.

Seconded.

After an explanation by Dr. Frank Billings, Illinois, to the effect that such a committee was appointed at Boston and had not been discharged, Dr. Arthur T. McCormack, Kentucky, moved to amend that the Speaker be empowered to appoint such additional members of the committee as he deemed fit who lived preferably near Washington.

The amendment was seconded, accepted, and the original motion as amended was put to a vote and carried.

With reference to Section 5, regarding Red Cross aid, the committee moved the adoption of the recommendation, and that the Board of Trustees be instructed to convey the recommendation of the committee to the officials of the Red Cross.

Seconded and carried.

Concerning Section 6, Dr. Harris moved the adoption of the recommendation of the committee.

Seconded and carried.

Concerning Section 7, Dr. Harris moved that the amendment offered by the committee be referred to the Reference Committee on Constitution and By-Laws.

Seconded and carried.

Relative to Section 8, no action was taken.

Regarding Section 9, Dr. H. P. Linsz, Virginia, moved its adoption.

Seconded and carried.

Concerning Section 10, Dr. Harris moved its adoption.

Seconded and carried.

With regard to Section 11, Dr. Harris moved its adoption.

Seconded and carried.

Regarding Section 12, Dr. Harris moved its adoption.

Seconded and carried.

Relative to Section 13, Dr. Harris moved its adoption.

Seconded and carried.

Concerning Section 14, Dr. Harris moved its adoption.

Seconded and carried.

With regard to Section 15, Dr. Harris moved its adoption.

Seconded and carried.

With regard to Section 16, Dr. Harris moved the adoption of the recommendation.

Seconded and carried.

Concerning Section 17, Dr. Harris moved the adoption of the recommendation.

Seconded and carried.

Regarding Section 18, Dr. Harris moved its adoption.

Seconded and carried.

Dr. Harris then moved that this partial report of the Reference Committee on Reports of Officers as presented and amended be adopted as a whole.

Seconded and carried.

Dr. Harris stated that the committee would finish its work and report to the House of Delegates later.

Report of Board of Trustees

Dr. Oscar Dowling, Louisiana, Chairman, presented the following report for the Board of Trustees:

To the House of Delegates:

The communication from the Veterans' Bureau to the House of Delegates requesting that the Medical Division of the Veterans' Bureau for delegate representation in the

House, which was referred to the Board of Trustees, has received consideration by the Board, as follows:

1. The Board has directed the Secretary of the Association to inform the director of the Veterans' Bureau that the Constitution and By-Laws of the Association will not permit this request to be granted.

2. The Board is of the opinion that the House of Delegates should express to the director of the Veterans' Bureau that the American Medical Association is willing and ready to cooperate with the bureau in the promotion of the efficient care of the disabled veterans of the World War. The Board recommends that the House take this action.

Dr. Arthur T. McCormack, Kentucky, moved the approval of the recommendation of the Board of Trustees.

Seconded and carried.

Dr. Dowling also presented the following for the Board of Trustees:

WHEREAS, The Medical Section, American Friends Service, through its Physicians and Surgeons Committee, appeals for American Medical Aid for the physicians of Russia, and

WHEREAS, This appeal has been presented to the House of Delegates and by the House has been referred to the Board of Trustees for additional action, be it

Resolved, That the matter of medical aid for Russian physicians receive the endorsement of the House of Delegates and that the President of the American Medical Association and the Board of Trustees be empowered to cooperate actively with the existing committees of the Medical Section, American Friends Service, to further this enterprise.

Dr. E. Eliot Harris, New York, moved the adoption of the recommendation.

Seconded and carried.

Dr. Dowling presented the following Resolutions from the Board of Trustees, which were referred to the Reference Committee on Amendments to the Constitution and By-Laws:

WHEREAS, Since the creation of the Council on Health and Public Instruction it has been relieved of two of the functions for which it was primarily established, namely, of its function pertaining to the organizing of the Association and to the Association's legislative activities;

WHEREAS, The activities of the Association in the fields of health and public instruction, for which in a large part said Council was created, are now centered to a considerable extent in the lay health journal, HYGEIA, published under the management of the Board of Trustees; and

WHEREAS, These changes in the functions of said Council seem to call for a revision of the methods by which they are performed:

Resolved, That the Council on Health and Public Instruction be and is hereby abolished, and the Board of Trustees authorized to establish and maintain in lieu thereof a Bureau of Health and Public Instruction to perform under direction of said board the functions now performed by said Council and such other functions as said board may assign to it;

Resolved, That the Board of Trustees be and is hereby authorized to appoint a committee to be known as the editorial advisory committee for HYGEIA, to cooperate with said board in determining the editorial policies of said journal; and

Resolved, That to carry into effect the purposes of the foregoing resolutions, the By-Laws be amended as follows:

Chapter VII, Section 3. Strike out "(*b*) Council on Health and Public Instruction," and reletter "b" and "c" respectively, the following two clauses:

Chapter VIII, Section 2. Strike out "of the Council on Health and Public Instruction and"; also "the salary of each"; and insert in lieu of the latter phrase, "his salary."

Chapter IX. Strike out Section 2 and renumber "2" and "3," respectively, by the following two sections.

Chapter X, Section 4, Par. (4). Strike out "(The members of the Council on Health and Public Instruction shall be members, *ex officio*, of this committee)."

Chapter VI, Insert after Section 1 the following section to be known as Section 2:

Section 2. The Board of Trustees shall establish a bureau, to be known as the Bureau of Health and Public Instruction, to carry on such activities in the field of health and the dissemination of information in relation thereto as the House of Delegates may direct or the Board of Trustees, in the absence of such directions may determine.

Section 3. The Board of Trustees shall publish a journal for the dissemination among the laity of information concerning health and matters of popular interest concerning medical matters, the editorial policies of which shall be determined by said board, with the cooperation of an editorial advisory committee, consisting of five members, appointed by said board from among the fellows of the Association.

Renumber "4" the section now numbered "2."

Make such merely verbal changes, if any, as may be necessary to carry into effect the purpose of the foregoing resolutions.

Resolution on Intern Training

Dr. George F. Keiper, Indiana, presented the following preambles and resolution, which were referred to the reference committee on Medical Education.

WHEREAS, The Boards of Medical Registration, Examination and Licensure of forty states require one year of intern training subsequent to graduation, as a prerequisite to the practice of medicine and surgery, and

WHEREAS, The detail of such intern training is in a very chaotic state because no curriculums of work and study exist. Be it

Resolved, By the House of Delegates of the American Medical Association that the Committee on Medical Education and Hospitals be instructed to prepare a plan for such intern training, and report the same to the next annual meeting of Delegates of this Association for consideration.

Proposed Amendment to By-Laws

Dr. George F. Keiper, Indiana, presented the following amendment to the By-Laws, Chapter I, Section 2, which was referred to the Reference Committee on Amendments to the Constitution and By-Laws:

TERM.—The last sentence to read:

Delegates and alternates elected by the sections, or delegates appointed from the United States Army, United States Navy and the United States Public Hecalth Service shall hold office for three years, so that one third shall be elected by the section each year and one third appointed from the government service each year.

On adoption of this By-Laws the following sections each shall elect a delegate and an alternate to serve for three years: (1) Practice of Medicine; (2) Surgery, General and Abdominal; (3) Obstetrics, Gynecology and Abdominal Surgery; (4) Ophthalmology, and (5) Laryngology, Otology and Rhinology.

The following sections each shall elect a delegate and an alternate for two years: (1) Diseases of Children; (2) Pharmacology and Therapeutics; (3) Pathology and Physiology; (4) Stomatology; (5) Nervous and Mental Diseases.

The following sections each shall elect a delegate and an alternate for one year: (1) Dermatology and Syphilology; (2) Preventive and Industrial Medicine and Public Health; (3) Urology; (4) Orthopedic Surgery; (5) Gastro-Enterology and Proctology.

Thereafter each section shall elect a delegate and alternate to serve for three years.

If a vacancy occurs from any cause, in any section representation, the section at the next annual meeting shall elect a delegate or alternate to fill out the unexpired term.

Gorgas Memorial

Dr. Charles W. Richardson, District of Columbia, and member of the Board of Trustees, spoke on the Gorgas Memorial, stating that this committee had continued its activities up to the time there was a reorganization made in the General Gorgas Memorial Committee. This committee has been in touch with the reorganization plans, and in order that the House of Delegates may receive a full and complete report of the reorganization made by the joint committee, he asked that Dr. Franklin H. Martin be extended the privileges of the floor to explain to the House of Delegates the methods to be adopted in order to obtain subscriptions for this purpose.

It was moved and seconded that Dr. Martin be extended the courtesies and privileges of the Board to speak on the General Gorgas Memorial Institute of Tropical and Preventive Medicine. Carried.

Dr. Martin then submitted the following report:

GORGAS MEMORIAL INSTITUTE OF TROPICAL AND PREVENTIVE MEDICINE

Our plans, as they affect the past and the future, and as they are worked out up to the present time, are as follows:

1. The Gorgas Memorial was organized under the laws of the state of Delaware with Admiral Braisted, Hon. John Bassett Moore, Surgeon General Ireland, Surgeon General Stitt, Surgeon General Cumming, Dr. Leo S. Rowe, Hon. Jose E. Lefevre of the Panaman Legation, President Belisario Porras of Panama, and Dr. Franklin Martin as the sponsors.

2. The object of the organization is to raise money, the interest of which will sustain a working memorial to General Gorgas, whose genius stamped out yellow fever and malaria in Cuba and Panama, and who taught us how to control those diseases.

3. The memorial is to be known as the Gorgas Memorial Institute of Tropical and Preventive Medicine, and will take the form of a research laboratory and a teaching institute in Panama for those branches of medicine.

4. The headquarters of this institute will be presided over by a board of scientific directors, of which Prof. Richard P. Strong, of Harvard University, has been selected as the first director. The institute will be located in Panama on a beautiful site on the shore of the Pacific, which was formerly in the exposition grounds of the city of Panama. The site was donated by the Republic of Panama, and President Porras, backed by the citizens of Panama, has guaranteed the initial buildings.

5. It is the plan of the directors of the institute to raise the sum of five million dollars, which will be invested in

trust securities, and only the interest of which is to be used to carry on the purposes of the organization.

6. The board of directors is composed of the following named men:

Honorary President, Warren G. Harding, President of the United States.
Dr. Belisario Porras, President, Republic of Panama.
Surgeon General Merritte W. Ireland, United States Army, Washington.
Surgeon General Hugh S. Cumming, United States Public Health Association.
Dr. Seale Harris, President, Southern Medical Association.
Mr. Bernard Baruch, New York.
Wr. W. P. C. Harding, President, Federal Reserve Bank, Boston.
Mr. Fred W. Upham, President, Consumers Company, Chicago.
Dr. W. H. G. Logan, Professor of Oral Surgery, Chicago College of Dental Surgery.
Dr. Gilbert Fitz-Patrick, Chairman Board of Control, American Institute of Homeopathy, Chicago.
Dr. Leo S. Rowe, Director-General, Pan American Union, Washington.
Surgeon General Edgar R. Stitt, United States Navy, Washington.
Brig. Gen. Robert E. Noble, Surgeon General, Library, Washington.
Hon. R. J. Alfard, Panaman Minister, Washington, D. C.
Judge John Bassett Moore, Court of International Justice, The Hague.
Mr. Samuel Gompers, President, American Federation of Labor.
Brig. Gen. Charles G. Dawes, President, Central Trust Company of Illinois.
Mr. Adolph Ochs, Editor, New York *Times*, New York.
Dr. Frank Billings, Chicago.
Vice President and Chairman of Board of Directors, Dr. Franklin Martin, Director-General, American College of Surgeons.
Attorney, Mr. Silas Strawn, Chicago.

The chairman of the board of directors has been asked to assume the responsibility of conducting the campaign for raising the money, which carries with it the establishment of headquarters in Chicago, where the Chicago members of directors will act as an executive committee.

7. (*a*) The campaign will be carried on under the direction of a committee of one hundred physicians and civilians in each state of the United States, each province of Canada, and each of the Latin American republics, with the governor of each state or province, and the president of each Latin American Republic to be asked to become honorary chairman of the respective committee.

(*b*) Each state and province will establish a committee of ten in each county, and in each city of over a hundred thousand inhabitants; and subcommittees of five in each ward of the larger cities.

(*c*) These committees will be called "contributing committees," and they will be composed of civilians who knew and appreciated the work of General Gorgas, and the more than 120,000 medical men who volunteered to serve as officers under General Gorgas during the World War, and who knew him more or less personally. Each committeeman will be expected to make a minimum subscription of one hundred dollars.

8. In our intensive campaign, our committee will interest:

(*a*) The labor organizations, which are deeply interested in Gorgas because of his campaign for sanitary housing of the men.

(*b*) Commercial organizations interested in trade in the tropical countries, which Gorgas' work made habitable.

(*c*) The school children, among whom a propaganda will be conducted making known in a simple way the sanitary principles that involve the destruction of the mosquito and the fly.

(*d*) The medical profession, many members of which served as reserve officers under the command of General Gorgas, and who knew him as a soldier and as a sanitarian as well.

(*e*) The governments of the Western continents, the amount asked to be distributed on a pro rata basis, according to the population of each country.

(*f*) The public, through three definite popular campaigns for smaller sums near the end of the drive:

i. A definite tag day in all cities and towns.

ii. A popular subscription conducted through the school children.

iii. A Gorgas' Sunday, on which subscriptions will be taken in all churches.

9. The campaign will extend from Oct. 3, 1923 (the anniversary of General Gorgas' birth) to July 4, 1924 (the anniversary of his death).

10. Propaganda regarding the memorial will be disseminated through newspapers of the United States, and the several other countries interested. A series of paragraphs will be released in advance with the understanding that they are to be printed on definite days, so that simultaneously all over the territory covered there will be a similar daily and weekly release of information that will keep the people interested in Gorgas and his work. At the head of this campaign we hope to have the editor of the New York *Times*, Mr. Adolph Ochs, who was a friend of General Gorgas, and who is deeply interested in the memorial.

The carrying out of this campaign, which will have its formal beginning, Oct. 3, 1923, will be preceded in the interval of three months by the perfecting of a gilt-edged list of men from whom we may expect to obtain subscriptions; and just before the opening of the formal campaign in October, a carefully worded, appealing letter will go to at least one hundred thousand selected individuals—men who were more or less in touch with Gorgas and who knew his work—each of whom will be asked to become a founder member of the organization, backed by a subscription for one thousand dollars. The rank and file of our committeemen, as has been stated, will be asked to subscribe one hundred dollars; and no one, except as he may influence individuals through the organization, will be asked to make any personal solicitation for subscriptions. We are hoping to secure from five hundred to one thousand of these preliminary founders' subscriptions. We are quite sure that a considerable number of the physicians and surgeons of the United States—prominent men in the profession—who served under General Gorgas, will make this preliminary subscription.

Dr. Arthur T. McCormack, Kentucky, moved that the House of Delegates, by rising vote, pledge the American Medical Association to do everything in its power to assist the Committee on Gorgas Memorial to erect this memorial to this great leader.

Seconded and unanimously carried.

Resolutions on Unlawful Prescribing of Liquor

Dr. Thomas C. Chalmers, New York, offered a resolution commending the work of the Association for the Protection of Constitutional Rights, which was referred to the Committee on Legislation and Public Relations. The text of this resolution will be appended to the report of the Reference Committee.

Dr. Thomas C. Chalmers, New York, presented the following resolution, which was referred to the Reference Committee on Rules and Order of Business:

WHEREAS, The honor and integrity of the medical profession are being impugned by the unnecessary, unprofessional and unlawful prescribing of liquor by unprincipaled physicians:

Resolved, That in the judgment of the House of Delegates, of the American Medical Association, in session assembled, every state and county medical association should use its best endeavor to discipline physicians who either negligently or wilfully prescribe liquor otherwise than in accordance with law, and to purge the medical profession of physicians who wilfully, under the cloak of their profession, prescribe liquor for other than medicinal purposes; and

Resolved, Further, that the Secretary of the Association send a copy of this resolution to every state and county medical association affiliated with the American Medical Association.

Resolutions on Whisky Bottled in Bond

Dr. Chalmers also presented the following resolutions which were referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, The interests of the patient and the success of the physician require that such alcoholic liquor as is prescribed in the treatment of disease be of known purity and standard strength; and

WHEREAS, This can be accomplished only by the marketing of bottled in bond whisky in containers suitable for the dispensing, unopened, by the pharmacist to the patient in such sizes as will meet the patient's need:

Resolved, That the Commissioner of Internal Revenue and the Prohibition Commissioner be again urged to limit as speedily as possible the distribution of whisky to bottled in bond packages, and to provide for the bottling in bond of whisky for medicinal use in packages of sizes suitable for dispensing unopened on prescription, say in packages of 4, 6, 8 and 16 ounces; and

Resolved, Further, that the Board of Trustees be requested to use its best endeavors to accomplish the ends named in the preceding resolution.

Dr. Cornelius Van Zwalenburg, California, presented the following resolution, which was referred to the Reference Committee on Sections and Section Work:

WHEREAS, New discoveries in the practice of medicine are usually made by the combined efforts of small groups of workers and are usually presented before small groups of specialists in special sections, or special societies where their distribution and practical application are restricted; therefore,

Resolved, By the House of Delegates, that the Council on Scientific Assembly be instructed to arrange that wherever possible upon every section program there shall be at least one paper on some subject from some other specialty which is of particular interest to the section before which it is read.

For example, the effect of the roentgen ray on cancer should be presented before the Section on Practice of Medicine and also before the Section on Surgery, General and Abdominal.

Resolution on Volstead Act

Dr. Victor D. Veck, California, offered the following resolutions, which were referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, It has always been the policy of the medical profession to maintain the confidence of their patients as an inviolate secret, and

WHEREAS, The Volstead Act compels the physician to betray the confidence placed in him by his patient by publishing the nature of his illness, and

WHEREAS, The said Volstead Act dispenses with the judgment of the physician when treating his patients by limiting the amount of alcoholic remedies he may prescribe; therefore, be it

Resolved, That the House of Delegates of the American Medical Association expresses its disapproval of those portions of the said Volstead Act which interfere with the proper relation of the physician and his patient, and be it further

Resolved, That a copy of this resolution be sent to each of our Representatives in the House and the Senate of the United States.

Resolution on Prescribing of Organic Extracts

Dr. S. W. Welch, Alabama, offered the following resolution, which was referred to the Reference Committee on Medical Education:

WHEREAS, The indiscriminate and unscientific use of preparations containing organic extracts or endocrines is liable to produce seriously injurious effects, and whereas products containing such substances are now being widely exploited as cure-alls and prescribed by physicians who are misled by the unwarranted claims of certain manufacturers. Therefore, be it

Resolved, That this Association unqualifiedly condemns the methods and claims of the said manufacturers as being unworthy of the consideration of the medical profession.

Proposed Amendment

Dr. Holman Taylor, Texas, offered the following amendment, which was referred to the Reference Committee on Amendments to the Constitution and By-Laws:

Amend Sub-Section 4 of Section 4 (Committees) of Chapter 10 of the By-Laws by striking out the words in parenthesis, as follows: "(The members of the Council on Health and Public Instruction shall be members, *ex officio*, of this committee.)," and substitute therefor the following: "The Executive Secretary of the the Bureau of Legal Medicine and Legislation shall be *ex officio* a member of this Committee."

Resolutions on Radiology

Dr. Albert Soiland, California, presented the following resolutions, which were referred to the Reference Committee on Sections and Section Work:

WHEREAS, There are over one thousand members of the American Medical Association engaged in the practice of Radiology, and

WHEREAS, The science of Radiology enters into and cannot be dissociated from the practice of medicine and surgery, and

WHEREAS, Serious attempts are being made by civic and commercial bodies in different states to legalize and license the practice of radiology by laymen, therefore be it

Resolved, That the House of Delegates of the American Medical Association hereby recognize the science of radiology as an integral part of the science of medicine and surgery and, be it further

Resolved, That the House of Delegates of the American Medical Association authorize the formation of a section of Radiology.

Resolution on Physicians' Home Association

Dr. J. Richard Kevin, New York, presented the following resolution which was referred to the Reference Committee on Miscellaneous Business:

WHEREAS, The Physicians' Home Association is a national organization which provides a desirable and comfortable home for the aged and incapacitated physician; and

WHEREAS, The Physicians' Home Association has already established a branch home in New York State and four aged and incapacitated physicians are now enjoying the privileges without any expense whatever; therefore, be it

Resolved, That the House of Delegates assembled records itself as being in free sympathy with the magnanimous object of the Physicians' Home Association, and that the Editor of THE JOURNAL be requested, when consistent, to assist in the propaganda of this worthy organization.

Resolutions on Public Health

Dr Southgate Leigh, Virginia, offered the following resolution from the Medical Society of Virginia, which was referred to the Reference Committee on Miscellaneous Business:

Resolved, That the Council on Pharmacy and Chemistry of the American Medical Association be instructed to employ a trained publicity man, preferably a writer with an established reputation, whose duty it shall be to get into the lay press, daily papers, rural publications, magazines, etc., articles covering fully and accurately all of the activities of organized medicine.

Dr. Leigh offered the following resolution from the Medical Society of Virginia, which was referred to the Reference Committee on Medical Education:

Resolved, That the President and Secretary of the American Medical Association be instructed to confer with the medical directors of the larger life insurance companies which do preventive and educational health work wtih the object of securing their cooperation in educating the public about quacks and nostrums.

Dr. Leigh presented the following resolution from the Medical and Surgical Section of the American Railway Association, which was referred to the Reference Committee on Miscellaneous Business:

WHEREAS, The U. S. Public Health Service, in cooperation with the State and Territorial Health Officers Association has compiled a standard sanitary code suitable for the entire country; and

WHEREAS, This Code has already been adopted by twenty-five states of the Union as their state code; therefore be it

Resolved, By the House of Delegates of the American Medical Association that said code be approved by this body and be recommended to the remaining states of the Union for adoption.

Dr. Leigh offered the following resolution from the Medical Society of Virginia, which was referred to the Reference Committee on Hygiene and Public Health:

Resolved, That the Council on Health and Public Instruction be instructed to supply each and every county medical society making the request with properly prepared articles for publication in the lay press covering the prevention of disease, the cause of disease, and such general information covering the work of the physicians as will tend toward a better understanding between the profession and the public.

Report of Special Committee on Survey of Systems of Drugless Therapy

Dr. Charles E. Humiston, Illinois, Chairman, presented the following report of the Special Committee on Survey Systems of Drugless Therapy:

In accordance with a resolution passed by the House of Delegates in 1922, President de Schweinitz appointed a committee of five members of the American Medical Association to cooperate with other organizations in a survey of the various forms of drugless therapy.

In view of the fact that your committee was not given the initiative in this proposed survey and in view of the further fact that none of the organizations proposing such investigation has invited cooperation by the American Medical Association, your committee is unable to do more than report progress.

However, your committee having ascertained that a large number of influential agencies approve the making of a thorough and impartial study of the value of the widely practiced forms of treatment of human ailments, recommends that the American Medical Association continue to offer its cooperation in this highly important matter.

A. D. DUNN,
F. B. LUND,
CHARLES E. HUMISTON.

At the conclusion of the report, Dr. Humiston moved its adoption, which was seconded and carried.

As there was no further business to come before the meeting, the House of Delegates took a recess until Thursday, June 28, at 2 p. m.

(To be continued)

Number of Lepers in World Estimated.—At a meeting of the Society of Arts, Sir Leonard Rogers, lecturer at the London School of Tropical Medicine, estimated that there were 500,000 lepers in India, 7,000 in Europe, 1,256,000 in Asia and 525,000 in Africa.

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

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SATURDAY, JULY 7, 1923

SAN FRANCISCO SESSION

The annual session of the American Medical Association in 1923 at San Francisco was a notable demonstration of the advance which medical science has made in the western part of the United States in the brief period since the Association met in the same place eight years ago. The registration (3,765) exceeded by almost 1,500 the registration at the 1915 meeting. In view of the distances traveled by those attending the convention, including even those from western states, this large registration is a remarkable testimony to the work of the Association on the Pacific Coast.

A conspicuous feature of the San Francisco session is the fact that not only the exhibits and the meeting of the House of Delegates were held in the Civic Auditorium, but also the meetings of all the sections. This enabled the Fellows to go rapidly from one meeting to another and permitted selection of the various papers in the various sections which were of particular interest to the individual physician. The scientific program was noteworthy for the advanced character of the subjects discussed. None of the newer procedures in diagnosis and treatment seems to have been overlooked. Of particular interest were symposiums on diet, on the mental health of the child and on preventive medicine, which attracted large numbers. An unusual feature of this meeting was the extensive publicity given to the work of the Association, not only by the press of San Francisco, but also by newspapers throughout the country. All the local papers assigned special staffs to cover the meeting and devoted from two to three pages each day to reports of the session. Physicians of California expressed the belief that the information thus given to the public through the lay press would be of great service in combating the advertising of the nonmedical cults, which has been particularly obnoxious in that state.

The main hall of the Civic Auditorium was occupied by the scientific and commercial exhibits. In the scientific exhibit special arrangements had been made to demonstrate particularly problems associated with the diagnosis and prevention of disease, and large numbers of persons constantly availed themselves of the opportunity to receive first-hand demonstrations of newer procedures in these fields. The motion picture theater, a part of the scientific exhibit, was likewise devoted primarily to diagnosis and was constantly attended by from 300 to 500 persons. In view of the distance to be traveled, the extent and scope of the commercial exhibits was a demonstration of the interest taken in the annual session by the manufacturers of drugs and foods, by the makers of apparatus and by medical publishers. Every foot of available space was occupied, and exhibitors expressed themselves as more than satisfied with the attention given to the displays.

In a special resolution, the House of Delegates of the Association tendered its thanks to the local Committee of Arrangements for the excellence of preparation and the thorough efficiency in its conduct of the meeting. As has been said, the main meeting hall is especially adapted to sessions of the Association. The opening meeting was held in an auditorium seating more than 6,000 persons, and every available space was occupied. The President's reception was held in the three ballrooms of the Fairmont Hotel and was an exceptionally well-arranged, beautiful and entertaining feature. Women visitors were provided with drives about the beautiful environs of the city, and a concluding event was the reception at Stanford University by President and Mrs. Ray Lyman Wilbur.

The climate of California justified its well-known reputation for evenness and salubrity. The weather during the entire meeting was clear and the range of temperature varied but a few degrees.

The sessions of the House of Delegates were fully and closely attended. As is shown by the minutes printed last week and continuing through the issues of this and next week, many problems of importance to the Association and to the public welfare received careful consideration. Attention is directed particularly to the actions taken relative to amendments to the Constitution and By-Laws of the Association.

The description would not be complete without mention of two unusual features. Through the local Committee of Arrangements, plans were made for clinics before and after the session. These clinics, held throughout the entire Pacific Coast and western states, carry the scientific work of the Association to many who were unable to register at the meeting. In order to convey an adequate view of medical California an extensive volume was prepared describing the work of the annual session and the medical features of every county in the state.[1]

1. Some extra copies of this book are available, and those interested may secure them by addressing Dr. William Musgrave, Balboa Building, San Francisco, chairman of the local Committee of Arrangements, to whom special thanks are due for executive efficiency shown in planning and carrying out the work of the meeting.

TREATMENT OF HYPERTENSION BY SALT RESTRICTION

The treatment of hypertension by salt restriction was advocated in 1904. There was some foundation for the doctrine in Widal's work on edema, but it was generally opposed except in France, where it found enthusiastic supporters. Allen's report,[1] in 1920, revived the subject, but seemed insufficient to convince many observers. Recently, Allen and Sherrill[2] reported 180 cases of hypertension treated by salt restriction which they believe provide a suitable test of the method.

The cases were limited to patients with a systolic blood pressure above 175 mm. of mercury. They were cases (1) of "essential" hypertension with plasma chlorid concentrations above 580 mg. per hundred cubic centimeters; (2) with plasma chlorid concentrations below 580 mg. per hundred cubic centimeters; (3) of hypertension and nephritis, and (4) of hypertension and diabetes. They were observed for periods varying from one month to four years. A normal blood pressure was restored in 18.9 per cent.; there was a "distinct therapeutic success" in 41.9 per cent., transitory benefit in 8.9 per cent., and complete failure in 30.5 per cent.

If, as Allen and Sherrill believe, hypertension is the result of injury to the small blood vessels of the kidneys, it seems probable that sodium chlorid, an important factor in osmosis, would affect this condition. The primary injury may be due to an infection or intoxication, but the progressive damage is said to result from a vicious circle formed by the kidney lesions and the retained chlorids. It appears that the plasma chlorid concentration of a normal person on a minimal salt intake is not above 580 mg. per hundred cubic centimeters, and that blood pressure and plasma chlorid concentration do not necessarily vary in parallel. Successes and failures were obtained in this series of cases almost indiscriminately, whether the plasma chlorids rose or fell, and it must be admitted that these variations are frequently due to laws unknown.

It is necessary to maintain strict salt privation. Diet is not considered "salt free" until 0.5 gm. or less of sodium chlorid is excreted daily. To accomplish such reduction, foods of very low salt content were selected and no salt was added to the food. The ability of patients to endure this diet is, it appears, evidence of abnormal chlorid metabolism. One hundred and nine patients were kept continuously on salt-free food. It was necessary in some cases to give from 1 to 3 gm. of sodium chlorid daily to prevent privation symptoms; this amount was allowed in other cases because it did no apparent harm.

A salt-free diet is exacting. It must be prepared in an appetizing manner, the tolerance in each case must be precisely determined, and the results of the diet must be checked by daily analyses of the chlorid output. It is therefore as much a hospital problem as is the dietary factor in the treatment of diabetes. Most of these patients had been treated by other methods before they were subjected to salt restriction. That the improvement which it was hoped would follow might not be ascribed to rest, the patients were not put to bed except for emergencies threatening life at the time of admission, and they were encouraged to perform a reasonable amount of physical exercise. In deliberate defiance of the protein restriction theory for the treatment of hypertension, patients without significant nitrogen retention were allowed from 80 to 100 gm. of protein a day. This did not impede the reduction of blood pressure in the average case, and extreme protein restriction did not improve the results obtained solely by salt restriction in the refractory case. The question of the susceptibility of hypertensive patients to injury from ordinary quantities of protein seems to have been answered. There was no immediate influence on blood pressure; there was in some cases a reduction of blood pressure by salt restriction even when an increase in the protein was allowed; there was no injury observed in a period of three years.

A supply of salt to the body may readily be conceived to be necessary, and its reduction beyond a safe level to be a risk. Symptoms of salt privation sometimes arise in severe cases. They are not, however, an essential part of the treatment, and they can usually be checked in their incipience. Thus salt restriction, accurately controlled for a sufficient length of time, has been found of value in hypertension. It is recognized that the majority of writers still oppose salt restriction, but it is believed that, under similar circumstances, others will achieve similar results.

1. Allen, F. M.: Arterial Hypertension, J. A. M. A. **74**: 652 (March 6) 1920.
2. Allen, F. M., and Sherrill, J. W.: Treatment of Arterial Hypertension, J. Metabol. Res. **2**: 429 (Oct.) 1922.

DEMENTIA PRAECOX AND ENDOCRINE DISORDER

It is only natural that a cause for diseases that seem unintelligible should be sought in the disturbance of functions about which we know little. Probably the most baffling common disease, if it is a disease and not, as many believe, a catch-all for psychiatric flotsam and jetsam, is that described under the name of dementia praecox. As the name is now used, the cases included in this group comprise approximately 50 per cent. of all admissions to hospitals for mental diseases and an even larger proportion of the total population of such institutions at any given time. The most fascinating and at the same time the least understood of all realms in physiology is that of the endocrine glands. Much effort has been directed to establishing a valid connection between these two sets of phenomena, which range from the now discredited Abderhalden reactions and studies of metabolism to the results obtained by

excision, transplantation and administration of gland substances. There is probably no gland that has not at some time been incriminated in the causation of dementia praecox. The pancreas, thyroid, thymus, hypophysis, suprarenals have all been accused, but probably none more frequently than the gonads.

One important result of these speculative considerations is the stimulus given to research on the anatomy of the ductless glands both in health and in disease. They have also brought into strong relief the need for care in interpreting and drawing conclusions from abnormalities observed. Such caution is especially important in connection with a chronic disorder like dementia praecox, which only exceptionally leads directly to a fatal termination. In all prolonged and severely incapacitating diseases, due consideration must be given to the secondary effects that are produced by the altered mode of life incident to the disease and to the coexistence of degenerative conditions and pathologic changes that arise from age, chronic infection and the intercurrent disease that actually causes death.

During the last few years, extensive investigation of the histology of the gonads from persons who have died while suffering from dementia praecox has been carried out in the laboratories of Mott [1] and has led him to the conclusion that in dementia praecox there is an atrophy of the gonadal parenchyma which is proportional to the duration of the mental disorder and the degree of psychic deterioration during life. From the clinical standpoint also attention has been called, notably by Gibbs,[2] to failure in the complete development of secondary sex characteristics, and by others, especially psychanalysts, to evidence of infantilism in dementia praecox which it is inferred should be ascribed to dysfunction of the gonads or hypophysis. The report by Morse [3] and his co-workers at the Boston Psychopathic Hospital on the results of studies of the endocrine glands is therefore especially valuable. Histologic examinations of various endocrine glands have been made in a series of twenty-seven cases of dementia praecox especially favorable for the purpose, including several cases in which death had been caused by suicide or accidental conditions. This material has been controlled as far as possible by identical studies of the glands in persons, dying from similar causes, who did not have dementia praecox. Morse finds that the conditions in the sex glands as well as the other endocrine glands "of the controls were essentially the same as in the dementia praecox cases for the same terminal diseases, with the exceptions of the feeble-minded, the infantile and the emaciated cases." He also asserts that careful study of his data fails to establish a correlation between the condition of the glands and the duration or degree of the mental disorder; and he concludes that it depends more on the nature of the terminal disease, the state of nutrition and possibly some underlying defects in development.

Morse also points out that aspermatogenesis, degenerations and profound atrophy of the gonads have been produced in animals by fasting, inanition, diets deficient in water soluble vitamins, experimental beriberi and by exposure to the roentgen ray. They have been described also in severe toxic disorders, especially in pneumonia, influenza and tuberculosis, in man. It is therefore not surprising that they are observed in dementia praecox cases, many of which end fatally from severe inanition, tuberculosis and other infectious diseases. It is true that negative evidence of this kind does not prove that there is no connection between dementia praecox and endocrine dysfunction, but it certainly does establish the need for positive findings under careful conditions of control such as have not yet been adduced, before the existence of such a correlation can be assumed even as a working hypothesis.

1. Mott, F. W.: Brit. M. J. 1: 463 (March 25) 1922; Proc. Roy. Soc. Med. (Sect. Psychiat.) 15: 1 (March) 1922; New York M. J. 116: 2[illegible] (Sept. 6) 1922.
2. G[illegible]s, C. E.: Sex Development and Behavior in Male Patients with Dementia Praecox, Arch. Neurol. & Psychiat. 9: 73 (Jan.) 1923.
3. Morse, M. E.: The Pathological Anatomy of the Ductless Glands in a Series of Dementia Praecox Cases, J. Neurol. & Psychopath. 4: 1 (May) 1923.

Current Comment

THE PRESIDENT-ELECT

The election of Dr. William Allen Pusey as President-Elect of the American Medical Association is a recognition not only of leadership in a specialty of medicine, but also of personal service to the American Medical Association and to medical science. Dr. Pusey was born in Elizabethtown, Hardin County, Ky., Dec. 1, 1865, son of Dr. Robert B. and Belle Brown Pusey. It is interesting to know that in 1922 Dr. Pusey presented a tablet to his native county as a memorial to Lincoln's foster mother, for Abraham Lincoln was born on a farm in Hardin County. The great grandfather of Dr. Pusey, William Brown, mapped the road from the Cumberland Gap into Kentucky. Dr. Pusey received the A.B. degree from Vanderbilt University in 1885, the A.M. in 1886 and the M.D. from the Medical College of New York University in 1888. The following year he began practice in Chicago. From 1894 to 1915 he was professor of dermatology in the University of Illinois School of Medicine and since that time has been emeritus professor. He has been dermatologist at St. Luke's and Augustana hospitals, and was president of the American Dermatological Association in 1910 and of the Chicago Medical Society, 1918-1919. During the war he rendered conspicuous service to the government as chairman of the Committee on Venereal Diseases in the Surgeon General's Office, outlining the plan of attack on these diseases and aiding in the preparation of the "Manual of Treatment of Venereal Disease," which was issued to every physician in the United

States. He is author of "The Roentgen Rays in Therapeutics and Diagnosis," of a textbook, "The Principles and Practice of Dermatology," which has passed through several editions, of "Syphilis as a Modern Problem" and of numerous periodical articles concerning diseases within his specialty. During 1922 he published "The Wilderness Road to Kentucky," in which he described the mapping of the road and its present condition as found on a personal trip which he made throughout its length. In 1910 he first described the use of solidified carbon dioxid, so-called "carbon dioxid snow," in the treatment of diseases of the skin. To the American Medical Association Dr. Pusey has rendered long, continued service. He was chairman of the section on diseases of the skin in 1909. From 1911 to 1922 he was treasurer of the Association. Since its foundation in 1920 he has been an editor of the *Archives of Dermatology and Syphilology*, published by the Association. In electing him to leadership the American Medical Association has recognized a man known for scientific ability in his chosen field, for executive ability as demonstrated by his work on important committees and councils, and for scholarship as exemplified by contributions to both medical and lay literature. It may confidently look to him to continue the promotion of the high ideals for which the Association stands.

SUBCUTANEOUS FIBROID NODULES IN RHEUMATISM

The development of nodules about the knees, elbows, wrists, knuckles, spine and occiput in acute rheumatism has been recognized for more than fifty years, and has long been considered an important diagnostic sign in England, where such nodules are sought as a matter of routine in all suspected cases. The nodules are subcutaneous and attached to the aponeuroses and tendon sheaths, the skin moving freely over them. "They vary from the size of a grain of sago to one or more centimeters in diameter." They produce no change in the skin, are painless, not tender, and disappear completely on recovery, leaving no discoloration or scar. Microscopically, they consist of a granulation tissue and have a close resemblance to the Aschoff bodies found in the heart muscle in rheumatic infections. In America, these nodules have been described by various authors in occasional cases, but have been considered decidedly unusual. It is interesting, therefore, to learn that Bronson and Carr of San Francisco, from whose report [1] the foregoing quotation is taken, have observed them in seventeen of thirty-eight cases of acute rheumatism in children. The diagnosis of this disease in children is often a matter of considerable difficulty, and yet, because of the serious consequences that are liable to ensue from inadequate treatment, of great importance. Bronson and Carr regard this sign not only as of great diagnostic assistance but also as of "more prognostic value than any other one sign." In arriving at the latter conclusion they divided their cases according to the severity of the disease, as indicated by the damage to the heart that resulted from the attack, into three groups. The incidence of the nodules in these groups was: in twelve cases in which the patients recovered practically without sequelae, one, or 8 per cent.; in nine cases with definite carditis but good functional recovery, three, or 33 per cent.; and in seventeen with crippling carditis, thirteen, or 77 per cent. Of the patients having nodules, 35.9 per cent. died during the two years of observation, whereas, in the same time, only one case without nodules ended fatally. The number of cases is small, but the figures are striking. Though it is possible that there are regional differences in the character of the infection, routine search and record in all cases of acute rheumatism in children are certainly indicated, especially in view of the intensive campaign against heart disease now in progress throughout the country.

1. Bronson, Edith, and Carr, E. M.: Am. J. M. Sc. **165**: 781 (June) 1923.

A TEST FOR TYPHOID INFECTION

A sensitive and apparently accurate method for detecting typhoid infection was recently reported by Laird, Conover and Butts.[1] It is a precipitation test which depends on the presence of autolyzed typhoid bacilli in the excretions and a rabbit's serum immune to a known specific typhoid bacillus. A small quantity of the stool of a patient is emulsified in physiologic sodium chlorid solution and allowed to stand until the insoluble part settles. The supernatant liquid is decanted, centrifugated, and decanted again. After the addition of diatomaceous earth and, finally, filtration, it is ready for the test. Urine, free from albumin, is similarly prepared. A precipitin rack is then set up having three test tubes for each patient; to the first and second row of tubes, 1 c.c. of typhoid serum is added; also, 1 c.c. of the filtrate of suspected feces or urine is added to the front tube, and a like amount of normal feces or urine to the middle tube. In the third tube, or back row, there is placed 2 c.c. of the specimen undergoing examination. The rack, thus arranged, is allowed to stand one hour at room temperature, in the icebox overnight, and at room temperature again in the morning for about four hours. Positive specimens then show a precipitation or turbidity in the front row of tubes. The controls, the second and third rows, are clear. The authors have used this test on 152 specimens of stool and urine from typhoid patients. They have tried it with autolysates of such other pathogenic intestinal organisms as *B. shigae, B. morgani, B. paracoli* and five strains of *B. dysenteriae* Flexner, and on normal excretions experimentally infected with *B. typhosus*. It has been specific in these instances, and accurate. It was clearly positive in all cases of typhoid fever up to the fifty-sixth day, and in all carriers examined, among whom there was one of eighteen years' standing. While this investigation has not been completed, the persistence of the positive autolysate-precipitin reaction after the bacteriologic tests now employed were negative, indicates an advantage in controlling typhoid patients and carriers. Results obtained

1. Laird, J. L.; Conover, J. R., and Butts, D. C. A.: The Autolysate-Precipitin Reaction in Typhoid Fever, Am. J. M. Sc. **165**: 241 (Feb.) 1923.

in the early stages of typhoid, it is said, give promise of usefulness in the field of diagnosis. Let us hope that the new test will eliminate the confusion in the diagnosis of typhoid in patients who have received typhoid prophylaxis.

TOXICITY OF CARBON TETRACHLORID

Severe attacks of pain and hematuria following the administration of carbon tetrachlorid in uncinariasis led Meyer and Pessôa [1] to conduct a series of experiments on dogs to determine what toxic effects this drug might have. They gave doses which varied from 0.1 to 3 c.c. per kilogram of body weight to twenty-five animals, and total amounts which varied from 0.2 to 28.5 c.c. It was noted in all cases when the dose was increased beyond a certain limit, which varied with the animal's weight, that "some effects of the carbon tetrachlorid became evident." It was found at necropsy (two animals died, the remainder being killed) that the liver was bright yellow and lusterless, and traced by yellow lines inclosing darker, depressed areas. A section of the liver showed a similar pattern. In some animals, these changes were much less marked, but an abnormal appearance was evident. The kidneys before section did not appear markedly abnormal. The cut surface, however, disclosed a brownish yellow zone in the cortex external to which there was a gray band "of linear threads radially arranged." Microscopic examination disclosed, in the severe cases, necrosis in the central portion of the lobule of the liver and a zone of fatty infiltration at the periphery of the acini. In animals in which central necrosis was less marked, the trabeculae showed "a sort of collapse," and evidence of central congestion was constant. Droplets of fat of various sizes in the vicinity of the portal spaces were apparent in the least affected animals. Microscopic changes in the kidneys consisted of droplets of fat in the epithelial cells of the loops of Henle and the convoluted tubules. These experiments were controlled by similar studies on dogs which were given no carbon tetrachlorid and whose liver and kidneys macroscopically were apparently normal. Microscopically, the amount of fat found in the control animals "in no way compared with the amounts noted in the cases in which the vermifuge had been administered," and none of them showed necrosis or degeneration in the liver or kidney. In view of these findings and the experience of Lambert in Fiji,[2] it would appear advisable that the dose of carbon tetrachlorid be reduced in routine treatments.

1. Meyer, J. R., and Pessôa, S. B.: Toxicity of Carbon Tetrachloride, Am. J. Trop. Med. **3**: 177 (May) 1923.
2. Lambert, S. M.: Carbon Tetrachlorid in the Treatment of Hookworm Disease, J. A. M. A. **80**: 526 (Feb. 24) 1923.

First Medical Schools in the New World.—The first school to teach medicine in the New World was the St. Thomas University at Santo Domingo, founded, Nov. 27, 1538. Next came the universities of Mexico and Lima, organized in 1551. At Mexico, however, medicine had been taught long before at the two schools for Indians established by Bishop Zumárraga and Pedro de Gante. Next came the universities of Bogotá (1572); Cordoba (1613); Sucre (1623); Guatemala (1675); Cuzco (1692); Caracas (1721); Havana (1728), and Quito (1787).

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION, PUBLIC HEALTH, ETC.)

ALABAMA

Sanitary School Established.—At the graduation exercises of the University of Alabama Medical School, University, it was announced that the Gorgas School of Sanitation will be established at the college as soon as funds are available.

Chiropractors Admitted.—According to rules adopted, June 14, chiropractors, and other "drugless healers" who are graduates of mechanic-therapy schools, will be granted certificates to practice in Alabama, provided they pass an examination to be given by the state medical board. New rules for the admission of physicians to practice in Alabama were formulated by the board in session, June 14, providing that the applicants shall be examined in chemistry, anatomy, psychology, physiologic chemistry, bacteriology, pathology and other branches of medical science.

ARKANSAS

Hospital Supplies Wanted.—Dr. Robert R. M. Wilson, Columbus, has sent requests to various hospitals and physicians for surgical instruments, drugs and hospital supplies for the Ellen Lavine Graham Hospital and Kwangju Leper Home at Kwangju, Korea, where there are 800 lepers. Any article weighing 11 pounds or less can be sent direct to Kwangju, Korea; for larger articles, the sender is requested to consult with Dr. Wilson at Columbus. Surgical instruments, tooth forceps, dental chairs, gauze, microscope, gowns, hospital clothing and Red Cross supplies are some of the articles most urgently needed.

CALIFORNIA

Chiropractic Board Ousted.—The five members of the chiropractic board of examiners appointed recently by Governor Richardson, under the Chiropractic Initiative Act of December, 1922, cannot continue to hold their positions on the board, by the terms of a decision handed down, June 19, by Superior Judge Perry in San Francisco. The opinion by which these men are ousted came about through the filing of a test case (THE JOURNAL, May 26, p. 1526). This suit was brought in order to determine whether the appointees were entitled to retain their positions since none of them have practiced chiropractic in accordance with the legal requirements in California for a period of three years.

FLORIDA

Dr. Harris Resigns.—Jesse R. Harris, lieutenant-colonel, M. C., U. S. Army, retired, has resigned as health officer of Tampa, to take effect, July 1.

County Health Departments.—With the assistance of the state board of health, twenty-four counties in the state during the past year maintained health departments, the total expenditures of which amounted to $214,831. These organizations quarantined 5,209 cases of contagious diseases by mail and 8,213 other cases in person; 46,922 complete typhoid vaccinations were given, 23,628 smallpox vaccinations and 909 whooping cough vaccinations; 13,925 children received the Schick test for diphtheria, and 2,118 homes where tuberculosis existed were visited.

GEORGIA

Monthly Clinics to Be Held in Five Cities.—Dr. J. W. Daniel, newly elected president of the state medical association, announced, May 4, graduate clinics would be held in five principal cities of Georgia every month or every other month, to offer the opportunity to physicians to study new scientific methods.

County Medical Meeting.—The LaGrange County Medical Society met at the Dunson Hospital, LaGrange, June 21, and elected Dr. Emory R. Park, president; Dr. Ruben S. O'Neal, vice president, and Dr. Emery C. Herman, secretary-treasurer. Dr. Henry R. Slack, the retiring president, stated that the society now has a large medical library and is out of debt.

Health Course in Atlanta.—In conjunction with the alumni reunion of Emory University School of Medicine, Atlanta, June 6-8, a conference of federal and state boards of health was held on clinical and social disease. The Fulton County Medical Association kept open house all week, and a symposium on acute medical and surgical abdomen was conducted, June 7. Dr. Thomas F. Abercrombie, state health commissioner, had charge of the program.

ILLINOIS

Research Laboratory Assured.—Governor Small has signed the bill appropriating the sum of $403,000 to establish a medical research laboratory at the University of Illinois.

Legislative News.—Among bills signed by the governor at the closing session of the legislature was a bill which excludes Chicago firemen from the provisions of the workmen's compensation act, a bill that defines "occupational diseases" as "accidental injuries" under the terms of the workmen's compensation act, and a bill to prohibit the use of milk substitutes in milk products.

Vacation Preventorium.—Through the generosity of the Champaign County Tuberculosis League, a preventorium for underweight and malnourished children will be conducted at the Outlook Sanatorium, Urbana, during the school vacation period this summer. The children will be given a three weeks' rest under medical supervision. About fifteen children will be accommodated every three weeks.

Epidemic of Smallpox.—At a special session of the city council of St. Charles, called, June 16, a ban was ordered on all public meetings as a result of the epidemic of smallpox then prevalent in the city. Dr. Alban L. Mann, Elgin, city physician, sent out a warning to unvaccinated Elgin residents, to avoid the possibility of the epidemic spreading to that city. A total of fifty-five cases of the disease are said to have been discovered in St. Charles.

Chicago

Personal.—Dr. Emil Mueller, Tripp, S. D., and D. Edward C. Rosenow, Rochester, Minn., addressed the Northwestern University Dental School, June 14.——Dr. J. Pou Orfila, professor of gynecology and obstetrics, University of Montevideo, Uruguay, recently visited Chicago.

Portable Baths for Children.—Portable shower baths for children in congested districts were ordered manufactured in the city shops and installed at once, by Mayor Dever, June 20. The baths, to be made of perforated iron pipe, will be attached to fire hydrants in suitable locations. Commissioner Sprague stated that should there be no appropriation available he would install the baths at his own expense. Firemen will be assigned to operate the sprinklers in each district.

INDIANA

New Society Organized.—The Indianapolis branch of the Association for the Prevention and Relief of Heart Disease, Inc., was organized, June 17. Dr. Charles J. McIntyre was elected president. The association will cooperate with the physicians and hospitals of the city in disseminating information concerning heart disease and in helping patients to find suitable employment. It will gather information on heart disease, develop and apply preventive methods, and promote the establishment of dispensary classes.

IOWA

Prison Sentence for Physician.—According to reports, Dr. Hugh S. Detchon, Victor, convicted in December, 1922, on a charge of criminal practice, has been sentenced to five years in the penitentiary. Detchon was fined $1,000 and costs at Marengo in 1915 on a charge of violating the prohibition law.

Health Center to Charge Small Fee.—Dr. Alexander D. McKinley, physician-in-charge of the Des Moines Health Center, announced that a change in the policy becomes effective, July 1. Except in the infant feeding school or tuberculosis clinics, patients will be charged 25 cents for the first visit and 10 cents for each succeeding visit. To June 1, 43,270 patients had been treated in the four years the clinics have operated.

KANSAS

Old Board of Health Sustained.—The state department of health resumed operation, June 16, with Dr. Milton O. Nyberg, Wichita, in charge, after virtually being closed for eight days (THE JOURNAL, June 16, p. 1781). The decision of the state supreme court, June 15, sustained the claims of the old board of health members to their positions.

LOUISIANA

Spinal Masseur in Jail.—The supreme court, New Orleans, June 21, denied the plea of Joseph B. Fife for writs of prohibition restraining Judge Byrnes of the civil district court from sending him to prison for ten days for contempt. Fife, who says he is a "scientific spinal nerve masseur," was sentenced for disobeying an injunction which restrained him from practicing. He was found guilty of practicing medicine without a license at Lake Charles in October, 1922.

MARYLAND

Colonial Hospital Opened to Patients.—Building C, the first unit of the recently organized Colonial Hospital, Baltimore, was opened, June 2. A formal opening of the hospital took place, June 15, at which time all three buildings were ready for occupancy.

MASSACHUSETTS

Federation of Examining and Licensing Boards.—The annual meeting of the New England Medical Federation of Examining and Licensing Boards was held in Boston, May 25. The following officers were elected for the ensuing year: president, Dr. Byron U. Richards of Rhode Island; vice president, Dr. George H. Janes of Massachusetts, and secretary, Dr. Samuel H. Calderwood of Massachusetts. A committee was appointed to consider laws relating to registration, to report at the next annual meeting.

Personal.—Dr. James J. Regan, Boston, has been appointed ophthalmologist of Cambridge City Hospital to succeed Dr. Henry Hawkins, resigned.——Dr. John B. Hawes, Boston, presented a paper on "Chronic Bronchitis" before the fortieth annual session of the American Climatological and Clinical Association, at Niagara Falls, Canada, May 23-25.——At the eighty-eighth annual graduation exercises of Lafayette College, held in Easton, Pa., June 11, the degree of doctor of science was conferred on Dr. Donald Budd Armstrong, Framingham.——Drs. Henry Colt, Pittsfield, and Ayers P. Merrill, Pittsfield, were elected president and secretary, respectively, of the Berkshire County Medical Society at the recent annual meeting.

MICHIGAN

University News.—The student body, alumni and friends have decided to establish a research endowment foundation at the Detroit College of Medicine and Surgery. This announcement was made by Dr. Louis J. C. Bailey at the annual meeting of the alumni, June 14. It is hoped to raise at least $100,000 to make the foundation permanent. It was announced that a scholarship in pathology, valued at about $18,000, has been raised during the past year, and that the alumni association is now engaged in raising a European scholarship of $20,000, which will enable the college to send at least one student to Vienna, Glasgow or Edinburgh each year. The library of the Wayne County Medical Society has been transferred to the college and the city has appropriated $9,000 for its maintenance for the first year. Dr. Howard W. Pierce was elected president of the alumni association.

MINNESOTA

University News.—A tract of 44 acres of land in Minneapolis on the banks of the Mississippi River, valued at $100,000, and an endowment fund of $900,000 have been given to the University of Minnesota for the construction and endowment of a hospital and convalescent home for crippled children. This gift is from William Henry Eustis, a former mayor of Minneapolis, who a month ago presented 21 acres of land to the city as a site for the Dowling School for Crippled Children, which the board of education of Minneapolis will erect. The children's hospital will be erected on the campus of the medical school, the board of regents announces, and the riverside tract will be retained as a site for the convalescent home. The hospital will have a capacity of fifty and the home of 250 patients.——Dr. Clemens Pirquet, professor of pediatrics at the University of Vienna, Austria, has been appointed professor of pediatrics at the University of Minnesota, Minneapolis.——Richard E. Scammon, Ph.D., has been appointed acting director of the department of anatomy during the year's absence of Dr. Clarence M. Jackson, who will serve as chairman of the medical division of the National Research Council during the coming year.

MISSOURI

Chiropractors Fined.—According to reports, B. O. Huntley, a chiropractor of St. Louis, was convicted on a charge of practicing medicine without a license, and fined $50.——Mrs. Viola Oswald, a chiropractor of Cape Girardeau, was arrested on a charge of practicing medicine without a license, and was fined $500 in the circuit court at Jackson, June 15.——H. H. Hilbert and A. J. Meyer, chiropractors of St. Louis, were recently prosecuted by the health department for practicing medicine without a license, it is reported. Both men were fined $50 and costs. It is alleged that Hilbert gave treatment to an investigator of the health department, for which he charged $2.

NEW JERSEY

State Medical Meeting.—At the one hundred and fifty-seventh annual meeting of the Medical Society of New Jersey, Atlantic City, June 21-23, Dr. Willis P. Eagleton, Newark, was elected president; Dr. Alexander MacAlister, Camden, first vice president; Dr. Archibald Mercer, Newark, second vice president, and Dr. Lucius F. Donahue, Bayonne, third vice president; recording secretary, Dr. John Bennett Morrison, Newark; corresponding secretary, Dr. William J. Carrington, Atlantic City, and treasurer, Dr. Elias J. Marsh, Paterson. The one hundred and fifty-eighth annual session will be held in Atlantic City in 1924. The society unanimously opposed the annual registration of physicians and voted hereafter to elect a president and three vice presidents on their merit, instead of the present practice of electing only the third vice president and elevating the other officials.

NEW MEXICO

State Medical Meeting.—At the forty-first annual session of the New Mexico Society at Albuquerque, June 19-21, the following officers were elected for the year 1923-1924; president, Dr. George S. McLandress, Albuqerque; vice presidents, Drs. Dudley B. Williams, Santa Fe, Thomas E. Presley, Roswell, and Percy G. Cornish, Jr., Albuquerque, and secretary-treasurer, Dr. Charles M. Yater, Roswell. Dr. Clark W. Hawley, Chicago, Dr. Leonard Freeman, Denver, and Dr. Max Einhorn, New York, were some of the out-of-town physicians who addressed the meeting.

NEW YORK

Personal.—Dr. Meredith F. Campbell, Trudeau, was recently awarded the Bellevue Alumni Science Prize for 1922, for original work on "Penile and Scrotal Gangrene." This is the second successive year that the prize has been awarded to Dr. Campbell.

Health Show to Be Annual Feature.—The health exhibitions of the past two years at Brooklyn will become an annual institution, it was announced, June 18, at the headquarters of the Safety Health and Sanitation Exhibition. The next exposition will be held October 20-27. Profits from the exhibition will be used in the form of a permanent fund as a nucleus to insure an annual health week for Brooklyn.

New York City

Smallpox Scare on Ship.—Seventy of the 120 passengers on the Clyde liner *Huron* from West Indian ports, which arrived, June 15, were sent to Hoffman Island for observation, because one of the ship's crew had smallpox.

Insurance Company Offers Health Scholarships.—The Metropolitan Life Insurance Company has donated, through the American Child Hygiene Association, a fund of $25,000 to be used as scholarships to teachers best fitted to promote health work in the schools. There will be fifty scholarships of $500 each. Applications will be received by the American Child Hygiene Association up to Dec. 1, 1923.

Health Department Serves Summons on Railroad Heads.—Officials of the Long Island Railroad were served with summons, June 22, to answer for violations of the Sanitary Code in allowing coal smoke to pour out of their yards at Morris Park and Long Island City. This action was taken by Health Commissioner Frank J. Monaghan, because of numerous complaints from residents living in the neighborhood of these yards.

New York Academy Delays Building Project.—The building committee of the New York Academy of Medicine has decided not to break ground for the proposed new building in October, as was at one time announced. The postponement of construction work is due to the fact that all the details of the plans have not yet been completely worked out and, in addition, the excessive cost of building operations has made it seem wise to hold up the project.

Neurological Institute Reports.—The report of the Neurological Institute for 1922, just made public, shows that during the year 29,956 patients were treated. Financially, the institution shows a small surplus. One of the chief features of the report deals with the work of the special clinic for maladjusted children, and more especially with the treatment employed to bring such children to a relatively normal state. During the last year, the clinical laboratory of the institute made 9,687 examinations, representing an increase of 505 over the previous year.

NORTH CAROLINA

Southern Pediatric Seminar.—A two weeks' graduate course in the diagnosis, prevention and treatment of diseases of infants and children will be given at Saluda, August 7-20. The following will deliver lectures: William A. Mulherin, associate professor of pediatrics, University of Georgia Medical Department, Augusta; Richard M. Pollitzer, professor of diseases of children, Medical College of South Carolina, Charleston; William P. Cornell, former professor of pediatrics, Medical College of South Carolina, Columbia; William L. Funkhouser, associate professor of medicine, Emory University School of Medicine, Atlanta, Ga.; Robert A. Strong, clinical professor of pediatrics, Tulane University of Louisiana School of Medicine, New Orleans; Charles V. Akin, Jr., of the U. S. Public Health Service; Owen H. Wilson, professor of pediatrics, Vanderbilt University Medical Department, Nashville, Tenn., and Robert Wilson, Jr., dean and professor of medicine, Medical College of the State of South Carolina, Charleston, and others.

NORTH DAKOTA

North Dakota Academy of Ophthalmology and Otolaryngology.—At the annual meeting in Grand Forks, May 31, Dr. Andrew Carr, Minot, was elected president; Dr. John P. Miller, Grand Forks, vice president, and Dr. Gustave Golseth, Jamestown, secretary-treasurer.

PENNSYLVANIA

Society News.—The forty-sixth annual meeting of the Pennsylvania Pharmaceutical Association was held at Bedford Springs, June 12-14, under the presidency of Harlan J. Mentzer, Blue Ridge Summit. Dr. Rufus A. Lyman, dean of the department of pharmacy of the University of Nebraska, addressed the members. The following officers were elected for the ensuing year: president, P. Henry Utech, Meadville; vice presidents, William E. Cline, Philadelphia, and Clarence Croft, Waynesboro; secretary, Louis Saalbach, Pittsburgh, and treasurer, F. H. E. Gleim, Lebanon. The next annual meeting will be held at Bethlehem, June 18-20, 1924.

Philadelphia

Personal.—Dr. William W. Keen completed fifty years on the board of trustees of Brown University, Providence, R. I., June 21. Dr. Keen, who is 86 years old, left for Europe, following the reading of a resolution, extending felicitations.——Dr. Florence L. Meredith, who recently resigned from the faculty of the Woman's Medical College of Pennsylvania, has been appointed physician of Smith College, Northampton, Mass., to succeed Dr. Florence Gilman.——The staff of the laboratory of the Henry Phipps Institute of the University of Pennsylvania gave a farewell dinner, June 18, in honor of Dr. Paul A. Lewis, for thirteen years director of the laboratory. Dr. Lewis has accepted a position at the Rockefeller Institute, Princeton, N. J.——A testimonial dinner was given, June 18, to Dr. Alice Weld Tallant, former professor of obstetrics at the Woman's Medical College of Pennsylvania at the home of Dr. Susan Rogers Corson.——The degree of doctor of science was conferred on Dr. George de Schweinitz, past president of the American Medical Association, by the University of Michigan, Ann Arbor, June 18.

RHODE ISLAND

New England Hospital Association.—At the second annual convention of the association in Providence, May 16-17, the following officers were elected for the ensuing year: president, Dr. Bennett L. Richardson, superintendent, City Hospital, Providence; vice president, Dr. Charles A. Drew, superintendent, City Hospital, Worcester, Mass., and secretary-treasurer, Dr. George A. MacIver, assistant superintendent, Massachusetts General Hospital, Boston.

SOUTH CAROLINA

University News.—At the ninety-fourth annual commencement of the Medical College of South Carolina, June 7, at Charleston, Dr. Robert Wilson, Jr., dean of the college, delivered the address. The following changes and promotions in the faculty were announced: Dr. Henry W. DeSaussure, lecturer in gynecology and obstetrics; Dr. Hawkins K. Jenkins, Jr., instructor in obstetrics, promoted to the position of lecturer in obstetrics; Dr. William L. A. Wellbrock, instructor in clinical pathology; Irving S. Barksdale, instructor in physiology and pharmacology; Dr. Theodore E. Bowers, assistant in surgery, promoted to the position of instructor in surgery; Dr. Charles A. Speissegger, assistant in gynecology; Dr. Archie E. Baker, Jr., assistant in pediatrics; Harry H. Wyman, Jr., assistant in chemistry to succeed Thomas L. McMeekin, who has recently resigned; R. E. Lee, assistant in bacteriology; E. C. Hood, assistant in physiology and pharmacology, and William Schirmer, promoted to lecturer in chemistry. James Marshall Neil, M.D., and Harold Eugene Rodgers, M.D., received honors in medicine.

UTAH

State Medical Meeting.—The twenty-ninth annual meeting of the Utah State Medical Association was held in Salt Lake City, June 20-22. Clinics were held in the hospitals of the city, and many members of the American Medical Association attended the sessions on their way through to San Francisco. Drs. Herman L. Kretschmer, Carl Beck and Albert J. Ochsner of Chicago; Harry H. Kerr, Washington, D. C.,; Emanuel Libman, New York, and Vilray P. Blair, St. Louis, were some of the visiting speakers. The following officers were elected for the ensuing year: president, Dr. Joseph R. Morrell, Ogden; president-elect, Dr. Sol. G. Kahn, Salt Lake City; vice presidents, Drs. Lashbrook B. Laker, Eureka, Thomas C. Gibson, Salt Lake City, and Homer E. Rich, Vernal; secretary, Dr. William L. Rich, Salt Lake City, and treasurer, Dr. Frederick L. Peterson, Salt Lake City.

WEST VIRGINIA

Society News.—The Cabell County Medical Association has organized a weekly luncheon club to meet every Wednesday at the Hotel Frederick, Huntington. Dr. Robert J. Wilkinson is president of the society and Dr. Andrew J. Swezey, secretary.

WISCONSIN

Personal.—Dr. John L. Yates, Milwaukee, gave a lecture on "Cancer, Its Treatment Based on Biological Aspects" before the Milwaukee Academy of Medicine, May 22.——Dr. William W. Johnston has resigned as health officer of Racine. ——Dr. Royal W. Dunham, Milwaukee, has been appointed head physician at the Cook County Tuberculosis Hospital, Oak Forest, Ill.

Society News.—Dr. Clavendon J. Combs, Oshkosh, was elected president of the Fox River Valley Medical Society at Green Bay, June 1.——The Kenosha County Medical and Dental societies were hosts to members of the Racine County Dental Society at a two-day meeting in Kenosha the last week in May. Clinics were held at St. Catherine's Hospital and the sessions closed with a banquet at the Elk's Club.—— At a meeting of the Milwaukee County Medical Society in Milwaukee, May 10, Dr. Arthur Cramp, Chicago, presented an illustrated lecture on the "Cult of Abrams." The society adopted the following resolution:

Be it Resolved, That the entire Abrams' method is such a palpable fraud that this society considers it beneath its dignity to appoint a committee to investigate it, and that the pursuit of the Abrams' method on the part of any member of this society shall be considered inconsistent with membership in the society.

A joint meeting of the Rock County Medical and Dental societies was held in Janesville, May 7. Boyd S. Gardner, D.D.S., Mayo Clinic, Rochester, Minn., gave an address on "The Relationship Between Focal Infections and Systemic Diseases."

WYOMING

State Medical Meeting.—At the twenty-first annual meeting of the Wyoming State Medical Society at Laramie, June 19-21, the following officers were elected for the ensuing year: president, Dr. Jesse D. Lewellen, Powell; vice presidents, Drs. Alexander B. Hamilton, Laramie, Edward S. Lauzer, Rock Springs, and John H. Conway, Cheyenne; treasurer, Dr. Chester Ellis Harris, Basin, and secretary, Dr. Edwin Earl Whedon, Sheridan. The next meeting will be held at Cody, about June 20, 1924. This session was held conjointly with the Wyoming State Dental Society. Among the visiting speakers were Drs. August F. Jonas, Omaha; Ora S. Fowler and Nathan B. Newcomer, Denver, and Vilray P. Blair, St. Louis.

CANADA

Personal.—Dr. Frederick M. McPhedran, Toronto, has been appointed assistant in clinical research in charge of the roentgen-ray department of the Henry Phipps Institute, Philadelphia.——Sir Robert Jones, M.D., of England, has been visiting Canada as a guest of the Canadian Medical Association.——Dr. Charles J. C. O. Hastings, health officer of Toronto, had the degree of LL.D., conferred by the University of Toronto, June 7.——Dr. Frederick G. Banting, Toronto, co-discoverer of the insulin treatment for diabetes, was listed for an annuity of $7,500 in the budget estimate in the Ottawa House of Commons, June 26, according to reports.

Medical Alumni Association.—At the first annual meeting and banquet of the Medical Alumni Association, University of Toronto, held in Windsor, May 31, 100 graduates of Toronto, Trinity and Victoria universities were present and the following officers were elected: honorary president, Dr. Alexander Taylor, Goderich; president, Harry B. Anderson, Toronto; secretary-treasurer, William Harley Smith, Toronto; vice presidents, Beverly D. Harison, Detroit; Archibald Moir, Peterborough; William A. C. Macdonald, Windsor; John N. Gunn, Calgary; Henry R. Parent, Ottawa; Arthur D. Smith, Mitchell; Allen A. Shepard, Sault Ste. Marie; Robert T. Noble, Toronto; James E. Davey, Hamilton, and Samuel Stewart, Thamesville.

GENERAL

American Psychiatric Association. — The seventy-ninth annual meeting of the association was held at Detroit, June 19-22, following the forty-seventh annual session of the American Medical Association for the study of the feebleminded. Dr. William M. Donald, president of the Wayne County Medical Society, delivered the address of welcome. Dr. Thomas W. Salmon, Larchmont, N. Y., professor of psychiatry at Columbia University, New York, was elected president; Dr. William A. White, Washington, D. C., vice president, and Dr. Clarence Floyd Haviland, Albany, N. Y., secretary-treasurer.

Industrial Bootlegging.—The commissioner of internal revenue and the American Chemical Society are cooperating to drive bootlegging from industry. The Alcohol Trade Advisory Committee will direct the nation-wide movement in this the first attempt to enforce the National Prohibition Act for the development of lawful industries that use alcohol as a raw material. William A. Sailor, Baltimore, president of the American Drug Manufacturers' Association, is chairman of the committee, and Harrison E. Howe, Washington, D. C., editor of *Industrial and Engineering Chemistry*, is secretary. An elaborate system of public information will be built up by the committee to guide the prohibition commissioner in controlling permits. The aim is to drive from commerce the bootlegger who, disguised as a wholesale druggist or a manufacturer of flavoring extracts, is able to sell alcohol to the drug trade and to physicians.

Institutions Given Funds for Insulin Treatment.—The institutions which will receive $10,000 from the Rockefeller Fund (THE JOURNAL, June 23, p. 1859) for the treatment of diabetes with insulin and which were selected by a committee of which Dr. Simon Flexner was head have been announced as follows: University of Michigan Hospital, Ann Arbor, Mich.; New England Deaconess Hospital, Boston; Presbyterian Hospital, Chicago; Lakeside Hospital, Cleveland; University of Iowa Hospital, Iowa City; Royal Victoria Hospital, Montreal, Canada; Touro Infirmary, New Orleans; Johns Hopkins Hospital, Baltimore; Barnes Hospital, St. Louis; Lane Hospital, San Francisco; Physiatric Institute, Morristown, N. J.; Toronto Hospital for Sick Children, and the Toronto General Hospital, Toronto, Canada. The Presbyterian Hospital, New York, will receive $15,000, and the University of Toronto, Banting-Best Fund, $5,000.

Bequests and Donations.—The following bequests and donations have recently been announced:

New York Association for Improving the Condition of the Poor, $300,000 for the establishment of a country home for nurses, and the New York Association for the Blind, $20,000, to maintain the Bourne Workshop, by the will of Miss Emily Howland Bourne.

Society for the Aid of Crippled Children, New York, $102,000 as the result of a street fair.

Yale University School of Medicine, New Haven, Conn., anonymous additional gift in payment of pledge for endowment of Anna M. R. Lauder Foundation of Public Health, $100,000, and an additional gift from Hon. Charles F. Brooker, in payment of pledge for principal of the Julia E. Brooker Fund.

Montefiore Home, New York, $50,000; United Hebrew Charities, Home for Aged and Infirm Hebrews, New York Guild for the Jewish Blind, and the Hebrew Orphan Asylum, $25,000 each; Mount Sinai Hospital, Beth Abraham Home for Incurables, Hebrew Infant Asylum, Hospital for Joint Diseases, Seton Hospital, Servants for Relief of Incurable Cancer, the Sydenham Hospital and the Lebanon Hospital, New York, each $5,000, under the will of Mrs. Hannah Heyman.

St. Elizabeth's Hospital, Utica, N. Y., $50,000, by the will of James Murphy.

Cornell University, Ithaca, N. Y., $50,000, for the erection of a tower, as a memorial to her father, by Mrs. Alfred G. Miles of New York.

Carney Hospital, Boston, $40,000, under the will of the Rev. John H. Fleming of Dedham, Mass.

Eudowood Sanatorium, Towson, Ind., $30,000 for the establishment of a children's pavilion, by Mrs. Henry Barton Jacobs, Baltimore.

Mount Zion Hospital, San Francisco, for a new nurses' home, $30,000, by Mrs. W. Hellman.

Mount Sinai Hospital, New York, and the Methodist Episcopal Hospital, Brooklyn, $25,000 each, by the will of Mrs. Eleanor von Koppenfels.

Jewish Maternity Hospital, Philadelphia, for building and equipping operating rooms in the new maternity building, $25,000, by the will of Mrs. Rosetta M. Ulman.

Lenox Hill and the New York Skin and Cancer hospitals, New York, each $20,000; New York Ear and Eye Infirmary and the Association for the Aid of Crippled Children, each $10,000, and the New York Ophthalmic Hospital, $5,000, by the will of Rudolph Keppler.

Arnold Gregory Memorial Hospital Association, Albion, N. Y., $12,000 for a nurses' home as a memorial to their father, George L. Burrows, by his children, the building to be known as the George L. Burrows Nurses' Home.

New York Homeopathic Medical College and Flower Hospital, the Babies' Hospital, the New York Orthopedic Dispensary, the Inwood House of Rest for Consumptives, and the Institute for Crippled and Disabled Men, New York, each $10,000, by the will of Miss Ethel L. McLean.

Meharry Medical College, Nashville, Tenn., $10,000 from Heman E. Perry of Atlanta, Ga.

Riverside (Calif.) Community Hospital, $10,000, by Frank A. Miller.

New York Skin and Cancer Hospital, $9,580, and the Manhattan Eye, Ear and Throat Hospital, $2,546, by the will of Mary Oakley.

Eastern Hospital for the Insane, Bearden, Tenn., $6,000, by the will of Mrs. Prudence M. Chambers of Warrensburg, Md.

Mount Sinai Hospital, $5,000; Montefiore Home for Aged and Infirm Hebrews and the Beth Israel Hospital, New York, each $1,000; the New York Association for the Blind and the Monmouth Memorial Hospital, Long Branch, N. J., each $500, by the will of Mrs. Clara Glazier.

Hillsboro (Ill.) Hospital, $5,000, by the will of Charles Ramsay.

The Samaritan Hospital, Philadelphia, $3,000; St. Mary's Hospital, and the Episcopal Hospital, Philadelphia, and the Home for Crippled Children, Atlantic City, N. J., and the Mercy Memorial Hospital, each $200, by the will of Anna D. Alburger.

Grace Hospital, Detroit, $2,000, by the will of Mrs. I. K. Moore.

Nashua (N. H.) Hospital Association, $1,000, by the will of Mayor Albert Shedd.

Home for Aged and Infirm Hebrews, Montefiore Home, the Lebanon and Beth Israel hospitals, New York, each $1,000, by the will of Marx Ottinger.

Kings Daughters Hospital, Columbia, Tenn., $1,000, by Edward Carpenter of New York.

Flushing (L. I.) Hospital, $1,000, by the will of Miss Subilla N. Seif.

Onawa Board of Health Laboratory, Onawa, Iowa, apparatus valued at more than $1,000, by Dr. Oliver Fisher.

Misericordia, Mount Sinai and the Milwaukee Maternity hospitals, Milwaukee, each $500, by the will of John Kopmeier of that city.

Twin City Hospital, Winston-Salem, N. C., $500, by Miss Edith Symington of Baltimore.

Grace Methodist Hospital, Hutchinson, Kan., a site for the new institution, by George Gano, late mayor of the city.

Children's Hospital, Boston, a Marmon touring car valued at more than $4,000, by the Jordan Marsh Company.

LATIN AMERICA

Organization of Chemists in Brazil.—The Sociedade Brasileira de Chimica was organized, May 2, on the initiative of the board of directors which arranged the first Brazilian Congress of Chemistry.

Portuguese-Brazilian Medical Congress. — The *Brazil-Medico* states that the Sociedade de Sciencias Medicas of Lisbon has appointed a committee to organize the Congresso Medico Luso-Brasileiro, but the selection of the place and date for the meeting is to be left to the organized physicians of Brazil. The Portuguese committee consists of the presidents of the three principal medical societies of Portugal, the Medica Lusitana, the Medicos do Centro and the Medicos do Norte, and seven other physicians.

Personal.—The *Brazil-Medico* states that the Brazilian Academy of Sciences recently reelected H. Morize, president; Juliano Moreira and D. Henninger, vice presidents; M. Ozorio de Almeida, secretary-general; Roquette Pinto and Mario Souza, first and second secretary, and Betim Paes Leme, treasurer.——During the absence from Brazil of the five official delegates to the Paris and Strasbourg congresses in honor of the Pasteur centennial, Dr. Leitão da Cunha will have charge of the public health service, in place of Dr. Carlos Chagas; Dr. Silva Araujo will have charge of the leprosy service in place of Professor Rabello, and Dr. Servulo, of the tuberculosis service, in place of Dr. Placido Barbosa, who takes Dr. Leitão Cunha's place temporarily. ——At the invitation of the Rockefeller Institute, Dr. Diego Hernández Fajardo of Yucatan is to visit New York and the institute.

FOREIGN

Cerebrospinal Meningitis in Formosa.—From March 21 to 31, seventy-four cases of cerebrospinal meningitis, with sixty-three deaths, were reported in the island of Taiwan (Formosa) Japan. The total number of cases reported from January 1 to March 31, was 538, with 269 deaths, in a population of 3,835,811.

Radium in Madagascar.—A scientific mission, composed of Professor Mourea, chemist at the Collège de France, his son and an assistant, has left Marseilles for Madagascar to examine the radio-active deposits which have been discovered on the island and to ascertain the properties of the thermal waters at Antsirabe.

Tuberculosis Conference Postponed. — The international conference, which had been arranged for discussion of the so-called Spanish theory of tuberculosis, has been postponed to the spring of 1924. The friends of Ferrán's alpha theory of the tubercle bacillus want an impartial discussion of his views, but found that more time was needed to compile data. Ferrán's theory was described in THE JOURNAL, June 10, 1922, p. 1833.

Retirement of Saltet.—The *Nederlandsch Tijdschrift voor Geneeskunde* reviews the career of Prof. R. H. Saltet in the public health service at home and in the Dutch East Indies, and gives a list of his numerous works on epidemiology, microbiology and physiology. He has reached the age limit, 70 years, and thus retires from the chair of hygiene and bacteriology at the University of Amsterdam and the laboratory of the public health service. He will settle in Berlin.

Quinin Wanted for Asia Minor.—A great shortage of quinin in the Russian Caucasus and Armenia and a consequent increase of malaria is reported by the Near East Relief. The director of relief operations urges that a large shipment of quinin be sent at once from the United States, stating that 10,000 kilos are needed in the Republic of Georgia alone, and that the government has been able to provide only a small fraction of the amount necessary. It is not obtainable at any price.

Rotary International Association. — Rotarians connected with pharmacy, medicine and allied professions met in Scarborough, England, May 9, for the purpose of organizing a vocational section. It was decided to include registered pharmacists, together with the allied professions of medicine, dentistry, veterinary surgery, and analytical chemistry. Dr. T. Stephenson, Edinburgh, was elected chairman for the ensuing year, and Mr. Kenneth McLennan, Edinburgh, secretary. The first regular meeting of the section will be held in London in July during the annual session of the British Pharmaceutical Association.

Medals Awarded.—Medals have been awarded by the minister of war for scientific work in France on war medicine and surgery from 1914 to 1921, to the following: Professor Moure, Bordeaux, for his "Guide for the Otolaryngologist in Wartime" and "The Organ of Hearing During the War," and to Professor Picqué, Bordeaux, for his "Remote Effects of Skull Wounds," also to the army surgeons: Bosredon for his "Military Identification" and "Interments in the Army"; Ginestous for his "Visual Index for Fitness for Military Service;" Rocher for his "War Osteomyelitis"; and Roquette, for his work, "The Installation and Functioning of the Hospital of Convalescents at Faucher."

Greek Physicians Refuse Reimbursement.—That the medical profession in parts of Greece is determined that the American Red Cross shall not use its funds to pay salaries of Greek physicians is revealed in reports to the American Red Cross Commissioner. This entails financial sacrifice in many cases as, in communities with a high ratio of refugees, the physician's remuneration from his practice is small, and the amount of time demanded by the treatment of refugees reduces even that sum. A letter from Volo, where there are 52,000 refugees, announced that Dr. N. Tsoukas and his assistant refused to accept remuneration for work at a child welfare station. A refugee physician on the island

of Chios assumed responsibility for a small clinic on that island. Other letters state that physicians in villages maintain clinics in their own homes so that refugees will not suffer when in need of medical attention. Work of this type often brings to light epidemic diseases in time to isolate the victims before the community is endangered.

The French League of Mental Hygiene.—The Ligue d' Hygiène mentale organized a public meeting in the great hall of the Sorbonne, in honor of Mr. Beers, secretary of the National Committee on Mental Hygiene of the United States, and the foreign delegates, Professors Ley, Brussels; Hascovec, Prague; Ferrari, Bologne; Christiansen, Copenhagen, and Belarmino Rodrigues, Barcelona, under the presidency of Mr. Justin Godart, former member of the cabinet. The meeting was attended by the ministers of the various departments interested in the league, and representatives of foreign legations. The throng was so great that more than 2,000 had to be turned away. After the opening address by M. Genil-Perrin, secretary of the league, and lectures by M. Toulouse, president of the organization, and others, among them Mr. Clifford W. Beers, on the international movement for mental hygiene, in connection with which he has started active propaganda for an international congress in Washington, 1925, a concert was given in which artists from the Comédie française, the opera, and others assisted. Among the speakers were Professor Ley, Mme. Jane Catulle-Mendes and Prof. H. Claude, who spoke on social poisons—morphin and cocain.

Personal.—Dr. Francos Rodriguez, a retired physician of Madrid, has been appointed senator for life.——The friends of Prof. R. Luzzatto are collecting subscriptions for the Luzzatto endowment for research on biochemistry and experimental therapy. Professor and Senator Albertoni is chairman of the committee in charge. Subscriptions are to be sent to the Economato, Universita di Modena.——The death is reported of E. Urban, the aged founder of the medical publishing house of Urban and Schwarzenberg of Vienna and Berlin.——Professor and Senator Sanarelli was appointed the official representative of Italy at the Strasbourg Pasteur Exposition, but the government has made no provisions for an exhibit beyond that of the state railways. Sanarelli consequently declined to serve, as the scientific progress of Italy was not presented as planned, and a leader in industry was appointed in his place.——Prof. P. Bastianelli of Florence, on his twenty-fifth anniversary as director of Alberti Hospital, was honored by a banquet and presentation of an engraved tribute.——A committee has been appointed at Catania to plan for honoring Prof. G. Clementi, chief of the surgical clinic. The plans include establishing a scholarship in his name.——Dr. A. Filè-Bonazzola, president of the Italian Federazione dei Medici liberi professionisti, recently suffered a grave automobile accident.——The municipality of Manduria, Italy, has conferred honorary citizenship on Dr. Carlo De Liso, and the surgical ward of the hospital has been given his name. He has presented the hospital with 100,000 lire.——Dr. Denker chief of the ear, nose and throat clinic at Halle, on the occasion of his sixtieth birthday, was given a purse of 4,000,000 marks to be used for furthering scientific achievements in his field, and was given a congratulatory address.——Professor Czerny has received 36,000,000 marks, collected by the Japanese pediatrists, for promoting scientific research at his clinic.——Dr. Gustav Bucky, Berlin, arrived in New York, June 12, on the S. S. *Pittsburgh*. He is commissioned by his government to make a study of roentgen-ray advances in the United States.——Dr. Alexis Carrel, Rockefeller Institute, New York, sailed, June 5, for his annual visit to his estate in France.

Deaths in Other Countries

Dr. **Julio Piñera,** Matanzas, Cuba, a medical officer in the army, was killed in a railroad accident.——Dr. **Gabriel Casuso y Roque,** professor of gynecology and dean of the medical faculty at Havana, at one time in charge of the department of agriculture. *Médica* says of him that he introduced modern aseptic methods into Cuba.——Dr. **J. M. Escuder,** Madrid, noted for his writings on psychiatry.——Dr. **Enrique Pérez Arce,** professor of pediatrics at the medical school of Guadalajara.——Dr. **J. Rückert,** professor of anatomy at Munich, aged 68.——Dr. **J. Nevinny,** professor of pharmacology at Innsbruck, aged 70.——Dr. **J. B. Rossi,** Marseilles, aged 90. He began the study of medicine at the age of 44, serving as health officer, and finally received his degree at the age of 66.——Dr. **C. N. van de Poll,** Amsterdam, one of the pioneers in obstetrics and gynecology in the Netherlands, died suddenly in the street, aged 65.——Dr. **H. Paschkis,** professor of dermatology and pharmacology, Vienna, aged 74.——Dr. **A. Solaro,** professor of pediatrics at Naples, injured in an automobile accident, aged 67.

CORRECTION

Impostor Assumed Dr. Ballin's Name.—A news item in THE JOURNAL, last week, p. 1943, stated that, according to reports, Dr. David B. Ballin, New York, was arrested in New Orleans, May 31, for having passed worthless checks in Memphis, Tenn. Dr. Ballin wires that the report is wholly untrue, and that he has informed the Memphis authorities that the prisoner is an impostor.

Foreign Letters

LONDON

(From Our Regular Correspondent)

June 11, 1923.

The Crisis in the Panel Service

As stated in a previous letter, the approaching revision of the terms of service of physicians under the National Insurance Act has given rise to a crisis. On the one side, some representatives of the friendly societies and a section of the press have denounced the service as perfunctory and inadequate, and demanded its reform and even its abolition. The position is complicated by the fact that the government has refused to continue an annual subsidy of about 50 cents to the capitation fee, granted in consequence of the increased cost of living due to the war, and that the representatives of the insured are unwilling to pay it. Hence the panel physicians face a possible reduction in the capitation fee, and are organizing to resist it, mainly by the mechanism of the British Medical Association. The Insurance Acts Committee of the association finds two currents of opinion in the public departments, local committees and friendly societies. One is that, at all costs, the capitation fee must be cut down; the other is that the service should be improved and made as good as possible, and that if this were done the capitation fee should not be reduced and even a larger one might be granted. The commitee decided to support the latter view, and to secure the support and ward off the antagonism of those holding it, recommended concessions on three points—free choice of physician, limitation of lists, and restatement of the range of service. At a meeting of representatives of the panel physicians, Dr. Brackenbury, chairman of the Insurance Acts Committee of the British Medical Association, stated that an expert investigation of the insurance fund showed that it contained reserves more than sufficient to meet any reasonable demands of the profession without any additional grant from the government. A substantial balance had been built up in consequence of a great decline in the incidence of sickness. A discussion at the Institute of Actuaries showed that in most of the large societies the incidence had never been more than 70 per cent. of that calculated, and in some of the years had fallen as low as 52 or 50 per cent. He attributed this improvement, in the main, to the work of the panel physicians, though there might have been contributory causes. After discussion, the conference agreed with the policy outlined by Dr. Brackenbury. It also declared that, in spite of some exceptions, the present medical service is a good one, securing for that large section of the population to which it applies medical care of a character and extent such as was never previously obtainable, and under conditions not, as a whole, inferior to those of private practice. The conference did not go into details as to the amount of remuneration, but was of opinion that any amount lower than that given as the result of arbitration in 1920 would not be adequate. It agreed that there should be an extension of service beyond the general practitioner range, and that a beginning

might be made with provision of increased diagnostic facilities (roentgen ray and laboratory).

The Octocentenary of St. Bartholomew's Hospital

The oldest of the London hospitals has celebrated its octocentary in a manner worthy of an event unique in the history of English medicine. The celebrations began with a service in the contemporary church of St. Bartholomew-the-Great, founded, like the hospital, by Rahere, the Augustinian canon. Ceremonies in the hospital square followed, and began with a procession of Augustinian canons from the four houses now established in England, preceded by a thurifer, a cross bearer and two bearers of lighted candles, singing a hymn in honor of St. Augustine, the music of which is traditionally ascribed to Rahere. A series of pageants representing episodes in the history of the hospital were then enacted. At the Guildhall, the Prince of Wales, who is president of the hospital, received addresses of congratulation from delegates from all over the world, representing the church, the universities of the empire and the United States and the learned societies. Dr. Alexander Primrose represented the University of Toronto, and Prof. William Henry Welch the board of scientific directors of the Rockefeller Institute. In the great hall of the hospital, a series of tableaus was presented, showing episodes in the history of the hospital, such as its building by Rahere, and other medical events, such as Harvey demonstrating the circulation of the blood to King Charles I. In the museum and library of the medical college there was an exhibition of historical documents connected with the hospital, including the actual grant, dated 1137, by Rahere of a church to Hagno, who succeeded him as master of the hospital; the charter granted to the hospital by King Henry VIII in 1544, and the indenture of apprenticeship of William Lawrence to John Abernethy, both famous surgeons of the hospital, dated April 30, 1799. The ancient "Bartholomew Fair" was revived as part of the ceremony. Here the students of the hospital took part in the celebration by carrying on the various side shows and booths by which money was obtained for the benefit of the hospital. The annual "old students" dinner was advanced from its usual place at the beginning of the winter session, so as to coincide with the celebrations. The company numbered 315, and included as guests many eminent representatives of other medical schools. Professor Welch, in an eloquent speech, said that Bart's was proud of its glorious past, but its face was toward the future. He declared that the backbone of American medicine was British, and that America was now beginning to pay something of her debt to British medicine.

Workmen's Compensation Bill

The government has introduced a workmen's compensation bill which widens the already wide basis on which compensation can be claimed. It proposes that accidents resulting in the death or disablement of a workman shall be deemed to arise "out of in the course of" his employment, notwithstanding that he acted in contravention of any statutory or other regulation or of any orders given by his employer, or without instructions given by his employer, if such act was done by the workman for the purpose of and in connection with his employer's trade or business. Another proposal is that in every factory (unless there is already a proper ambulance room with arrangements for the immediate treatment of injuries) there shall be a first-aid box or cupboard under the charge of a responsible person, who shall always be readily available during working hours. Where more than 150 persons are employed there is to be an extra box or cupboard for every additional 150 employees. Under the existing law, when employer and workman cannot agree as to the workman's condition or fitness for employment, the matter may be referred to a medical referee on payment of a fee by the applicant. It is proposed to do away with the fee and to allow reference on the application of either side, subject to appeal to the judge.

PARIS

(From Our Regular Correspondent)

June 8, 1923.

A Proposed Order of Physicians

What has been termed the "medical note-book scandal" has been creating considerable stir, of late, in the public press. For some time it has been the practice for physicians who attend ex-service men to record their visits in certain *carnets médicaux*, or medical note-books. At Marseilles and Versailles it has been discovered that certain physicians have recorded visits that they had not made, and have collected from the state enormous sums to which they were not entitled. In view of this scandal, a bill has been proposed in the chamber of deputies looking toward the creation of an Order of Physicians, analogous to the already established Order of Advocates. The proponents of the bill contend that public interest demands that physicians be, by legal enactment, grouped together in an organized "medical corps," which shall be accorded the right to impose penalties on "undesirables" in the profession without waiting for scandals to become public. The imposable penalties range from a simple reprimand to permanent cancelation of the license to practice medicine. For each district over which the sphere of influence of a school of medicine extends, the bill will establish a regional medical council, to which offenders would have the right to appeal.

This idea of an Order of Physicians is not new. The first movement in France in favor of such a professional organization goes back to 1845. The reason the idea has not been carried out is that it has always encountered serious objections. In opposition, it is urged that a practitioner deprived, through a sentence of the Order of Physicians, of the right to practice medicine can still respond to the appeals of patients who, in spite of everything, have not lost confidence in him and wish to be treated by him. If a lawyer, though disbarred, may become a consultant or an *homme d'affaires*, a physician, prohibited from practicing his profession, may become a bone-setter or healer, and will join the ranks of illegal practitioners against whom it is so difficult to contend.

The Sensibilities of Liquor Merchants

In a previous letter I referred to the leaflets on antivenereal prophylaxis that are given to young men who present themselves before the councils of review, or exemption boards. Among other suggestions contained in the leaflet is this advice: "Avoid alcoholic beverages and appetizers, for they are poisons." This sentence has naturally displeased the liquor merchants, and the president of the national syndicate of the wholesale wine, cider, spirituous liquor and liqueur dealers has sent a letter to the minister of commerce and industry, in which he maintains that "this brutal expression not only bears heavily on the interests but also reflects on the honor of a trade and industry which hold an important place in France. Affirmations of this nature in an official document furnish the prohibitionists of the old and new world most excellent material with which to support their contentions." The president of the syndicate requested the minister to secure "a modification of the objectionable sentence so that, in condemning alcoholism—that is to say, the abuse of alcohol, which no one defends—it may not include a general censure of perfectly harmless products, of which not only viniculture but also French industry and commerce in general are so justly proud."

In spite of this appeal to "patriotism," which was transmitted to the Société française de prophylaxie sanitaire et

morale by the minister of war, that society decided unanimously to request the minister to retain the incriminated sentence and to continue the antialcohol propaganda.

Professor Hayem as a Medallionist

At a recent meeting of the Academy of Medicine, Dr. Hanriot presented to the academy a medallion portrait of himself, which was the work of Professor Hayem. Hayem retired several years ago from the practice of medicine. Two years ago, he began to study the art of medallion portraiture, and rapidly acquired remarkable skill. In this connection, Hanriot remarked that very few physicians have become medallionists. Among these he referred to Robinet, a physician of the seventeenth century and founder of the Collège des médecins de Rouen; Cusco (1849-1894), member of the Academy of Medicine, and Paul Ricker, whose many medals commemorating events in medical history are well known, notably the insignia of the Congrès des sciences médicales des Lisbonne, the medal of the centenary of the Academy of Medicine, the medallions of Blanchard, Marey, Chauveau, Magnan, Lucas-Championnière, and others.

The Huchard Prize

The lamented Dr. Huchard bequeathed to the Academy of Medicine a certain sum the earnings of which are to be employed for the establishment of a biennial prize of 8,000 francs, which may be divided into two or three parts. It may be awarded to persons of French nationality belonging preferably to the medical profession (students, physicians, surgeons), and, exceptionally, to persons who are not members of the profession but who have been distinguished by devotion to the sick or to medical science. This year the committee of award bestowed the prize on three candidates, representing three aspects of devotion to medicine—a hospital intern, a nurse and a practitioner. Two of the persons thus honored have unfortunately passed on; namely, G. P. Perrochaud, intern of the hospitals of Paris, and Dr. J. J. G. Blanc. When the war broke, Perrochaud, whose recent death came as a shock to his co-workers and teachers, was rejected on account of chronic albuminuria following diphtheria. He therefore volunteered as an ordinary nurse, became an assistant physician and later *aide-major;* during the whole war he did not leave the trenches. He was awarded the croix de guerre with three citations, all of which emphasized his devotion and courage in bringing aid to the wounded under fire. Last year he was attached to the contagious disease ward in the Bretonneau Hospital, where he contracted scarlet fever of fulminating type, which in four days terminated fatally. He must have been aware that his renal defect lessened his chances for recovery from scarlet fever. Nevertheless, he did not hesitate to expose himself in the performance of his professional duties. Dr. Blanc, formerly member of the army medical corps, contracted typhus, to which he succumbed. The third portion of the Huchard prize was awarded to Mlle. Dauch, assistant director of the hospital school of the French Red Cross Society, who had served for twenty-one years in the Société de secours aux blessés militaires as a nurse, and who, in 1906, contracted severe typhoid fever, complicated successively by partial paralysis, necrosis of the ribs and lesions of the ear, which ended in complete deafness.

The Mortality in France from Diseases Caused by Micro-Organisms, Before and Since Pasteur

Dr. A. Calmette, assistant director of the Pasteur Institute in Paris, has just presented to the Academy of Medicine an interesting communication on this subject. On studying the general mortality figures for France, we find that, in 1890, for a population of approximately 38,300,000, there were 876,000 deaths exclusive of stillbirths, or 228 per thousand inhabitants. In 1910, in spite of the low birth rate, the population had increased slightly. The statistical reports showed 39,500,000 inhabitants, and the number of deaths was only 703,000, or 178 per 10,000 persons. During the post-Pasteurian period from 1890 to 1910, France was thus able to save each year an average of 90,000 human lives, representing, on a prewar basis, a benefit to society amounting to 2,250,000,000 francs.

The mortality from the principal infectious diseases in cities of more than 5,000 inhabitants was:

	Deaths in 1890	Deaths in 1890 per 100,000 Inhabitants	Deaths in 1910	Deaths in 1910 per 100,000 Inhabitants
Typhoid fever	5,302	42.2	1,792	12.4
Diphtheria	6,850	56.2	1,325	8.74
Measles	7,196	59.0	2,339	15.4
Scarlet fever	731	6.0	417	2.74
Pertussis	2,317	19.1	1,559	10.5
	22,456		7,432	

In twenty years the mortality from these diseases has thus been diminished two thirds.

Infant mortality, exclusive of the still-born, has decreased, but unfortunately the improvement is not marked as yet. A comparison of two quinquennial periods will show what progress has been made. In 935,000 living births from 1881 to 1885, 156,000 deaths occurred in children under 1 year of age, or 167 deaths per thousand births. From 1906 to 1910, 783,000 living births were recorded; of these children, 99,000 died under 1 year, which was 126 deaths per thousand births. The result thus shown is far behind what has been accomplished in this respect by Switzerland, the Netherlands, Denmark, Sweden and Norway; for in the two last mentioned countries the number of children per thousand living births dying under 1 year of age is only from 60 to 68. Before the Pasteurian era the record ranged from 100 to 140. Calmette stated that if France could succeed in securing the same results as Norway, where the general mortality is only 132 per 10,000 inhabitants, as compared with 178 in France (1910 report), we would see our population increase every year by 179,400, even though our birth rate did not rise above the present low mark.

The Visit of the Russian Physiologist Pawlow

The Russian physiologist I. P. Pawlow, who remained at Petrograd throughout the revolutionary upheaval and concerning whose safety much anxiety was felt, is at present on his way to Paris. He is coming to participate in the celebration at Strasbourg of Pasteur's centenary, and from there it is said he expects to proceed to the United States, where it is his intention to study the progress that has been made in physiology and experimental medicine. Thence he plans to return to Petrograd, stopping on his way in England, where he will attend the International Congress of Physiology.

The Seventeenth French Congress of Medicine

The Seventeenth French Congress of Medicine will be held in Bordeaux, Sept. 27-30, 1923. The subjects up for discussion are:

1. The remote sequels of paludism; by Professor Le Dantec of Bordeaux, with the collaboration of Dr. Hesnard, naval physician and professor at the Ecole de santé navale of Bordeaux, who will deal particularly with postmalarial psychoses, and of Dr. Marcel Léger, physician to the colonial troops, and director of the Physiologic Institute at Dakar, who will consider more especially the visceral lesions associated with malaria. Dr. Broden, director of the State School of Tropical Medicine at Brussels, will also discuss the topic.

2. The relations in pathology between the sympathetic nervous system and the endocrine glands, with a paper by Professor Pachon of Bordeaux; Agrégé Professor Perrin of Nancy will also discuss the subject.

3. The treatment of meningococcus infections, with papers by Dr. Dopter, professor at the Ecole d'application de médecine et de pharmacie militaires of Val-de-Grâce, and Dr. Boidin, physician to the hospitals of Paris. Dopter will deal more particularly with serotherapy, and Boidin with vaccinotherapy.

ROME

(From Our Regular Correspondent)

June 2, 1923.

Second International Congress of Military Medicine

This is the closing day of the Second International Congress of Military Medicine, the convening of which at Rome was previously announced. The sessions of the congress were held in the Celio military hospital at Rome, and in my next letter I hope to take up the different subjects that were discussed. Today I wish to emphasize the great success of this congress not only as regards the organization of the *services de santé* (army medical corps) but also with reference to the importance that must be attributed to this convention, at which more than thirty nations were represented, including France, England, Spain, Belgium, Holland, Switzerland and a number of South American countries. The United States sent as a delegate Commander William Seaman Bainbridge, who is also a member of the permanent committee on organization. The opening meeting, held in the large hall of the capitol and attended by the king of Italy and Prime Minister Mussolini, was imposing. A vigorous opening speech was delivered by Senator Cremonesi, who, in behalf of the Eternal City, welcomed the foreign delegates. General Diaz referred to the work of the Italian army medical corps which, during the war, 1915-1918, suffered great losses (257 physicians killed, 1,959 mutilated, 1,000 wounded). The formal inaugural address was delivered by General Della Valle, director general of the Italian army medical corps, who emphasized the world-wide importance of such meetings of officers of the various army medical corps. He pointed out that these opportunities for exchange of views between the organizations of the various armies may bring great results from the humanitarian standpoint—through an organization composed of members of the various sanitary services all of which are working toward the same end—care of the wounded of whatever nationality they may be. An understanding between the army medical corps of the various countries might constitute a first step—*inter arma caritas*—toward the establishment of a world peace. While looking forward to the realization of the world peace idea, General Della Valle discussed the present organization of the Italian army medical corps.

SPECIALIZED SERVICES

Della Valle took special pains to point out that the activities of the Italian army medical corps had been concentrated on the development of highly specialized services, on which the functioning of the sanitary service as a whole depends, especially the days when mobilization may require the highest effort of which all are capable. Without technical specialization, not only as regards personnel but also with respect to equipment, it will be impossible to cope with the innumerable exigencies that naturally arise in the various branches of the sanitary service. It is only through careful working out in advance of details with respect to organization and management and with reference to surgical equipment, epidemiologic control and rendering of first aid that the army medical corps will be able to cope with the situation when military operations on a large scale are launched.

ARMY SURGICAL AMBULANCES

One of the most conspicuous manifestations of this specialization was the creation of army surgical ambulances. The speaker called attention to the marvelous feats accomplished by these ambulances in that they could be driven close up to the firing line, where life-saving operations could be performed on the wounded whose serious condition made transportation impossible.

OTHER FORMS OF SPECIALIZATION

It is to the same principle of specialization that various other excellent institutions established by the Italian army medical corps owed their creation, including centers for physiotherapy and antituberculosis sanatoriums. General Della Valle ended his discourse with these words:

> After the great destruction wrought by the war, with the dawn of the reconstruction of nations, the Second Congress of Military Medicine has met to bring important contributions of a scientific and practical character toward the solution of the problems studied, and will thus tend to cement the bonds of union that unite all civilized peoples, since its sole purpose is the progress of humanity.

BERLIN

(From Our Regular Correspondent)

June 2, 1923.

Experimental Modification of the Ratio of the Sexes in Animals

In many animals there is a persistent preponderance of one sex over the other. For instance, in the case of the pig there are 117 males to 100 females; in the hawk family there are only 87 males to 100 females. This ratio, which, in the various species of plants and animals, presents an approximately constant value, may be modified by experimental intervention. Dr. Agnes Blum has for some time been conducting, experiments of this kind, with white mice, which possess great theoretical value. In white mice there are normally only 80 males to 100 females. These proportions may be considerably modified by the effect of chemical substances on the organism. The injection of certain definite quantities of alcohol caused the males to increase from 80 to 122. Also yohimbin raised the number of males from 80 to 120, but only when the drug was given to the males. When females were treated with yohimbin and mated with normal males, no increase in the number of males was noted, from which it is evident that the drug exerts an influence only on the male gonads. The results secured by the use of caffein were somewhat more complicated. The males had first to become adjusted to this poison. Until they did, the mortality was high, and among their offspring there were fewer males than before the administration of the drug. However, after the males became habituated to caffein, the number of males rose suddenly to 126, but later fell somewhat, doubtless when the stimulating effect of the caffein began to wear off. The reasons for the changed proportions are explained by Dr. Blum thus: There are two kinds of sperm cells, namely, female determinants and male determinants, which, according to Lenz's assumption, possess a different degree of motility. In mice, under normal conditions, the female determinants are more motile, so that more ova are impregnated by them than by the male determinants; hence, the preponderance of females produced. Through the effects of caffein, however, the motility of the male determinants is increased, with the result that the proportion of males is also increased. Although it cannot be said that this interpretation is established, yet experiments point, with a high degree of certainty, to the existence of two different kinds of sperm cells, which react in different ways to external influences.

Height and Body Weight in Relation to Social Classes

In the schools of Weissenfels (on the Saale), Dr. Wörner, director of the department of internal medicine at the

municipal hospital, has been making a comparative study of the height and weight of pupils, and has noted some remarkable findings, which he now reports in the *Deutsche medizinische Wochenschrift*. The difference between the pupils of the *Volksschule* (no foreign languages) and those of the more classical schools were very marked. Whereas the 7 year old boys in the three *Volksschulen* had a height of from 109 to 115 cm., the boys of the same age in the *Oberrealschule* (modern languages and higher mathematics) presented an average of 122 cm. In like manner, the weight of the former ranged between 19.5 and 20.5 kg., whereas the pupils of the *Oberrealschule* averaged 23.7 kg. Much the same difference was found in the boys, and also the girls, of various ages. For instance, the weight of girls aged 13, in the various *Volksschulen*, ranged from 32.4 to 34.6 kg.; the height, from 141 to 143 cm.; in the more classical lyceum, however, the figures were 40 kg. and 149 cm. The great difference in the social status of the parents of the two groups may doubtless be considered at least an indirect decisive factor influencing these findings. The *Volksschule* is attended mainly by children of the laboring class, the *Mittelschule* is patronized chiefly by the burgher class in modest circumstances, while the more classical schools draw their clientage more from the formerly comfortably situated middle class and from the wealthy class. The fact that, since the war, the middle classes have not been so well off as they were before the war does not seem to have had any very marked effect on the present generation of pupils. The question has been raised whether the greater height of the children of wealthy parents must necessarily be regarded as an expression of the true and normal type, and the shorter build found among the children of poorer parents as evidence of an inferior type. It has been suggested that possibly the tall children of the wealthier class may be compared to the less sturdy shoots of hothouse plants. Nutrition factors and mode of living play an important part in growth. Children of wealthy parents generally lead a more sedentary life, varied, at most, by light forms of exercise, whereas children of the laboring class are trained at an early age to do physical labor, being much in the open air. It is significant, too, that the pupils of the *Volksschule* have broader shoulders than the pupils of the *Oberrealschule*. Against the assumption that the greater height is due to stimulation by a highly varied and highly seasoned diet, containing an unusually large percentage of protein, may be urged the fact that only a very small proportion of the pupils in the Weissenfels schools taking the more classical courses are the offspring of wealthy parents, being for the most part the children of petty government officials, small merchants, artisans and mechanics. It is, however, doubtless true that the sedentary mode of living, together with moderate exercise, exerts considerable influence, especially in the case of children of the middle class, who, if they are selected to attend a classical school, are usually kept pretty close to their books by the urging of their parents. For the lower strata of the attendants at the *Volksschule*, the character of the diet, which is commonly low in vitamins, together with the housing factor, will doubtless furnish an explanation.

Nutrition of the People as Judged by the Results of Examinations of Life Insurance Policy Holders

Dr. Fischer reports in the *Klinische Wochenschrift* the results of his researches on the significance for the nutrition of the people of the statistics on height and weight secured through an examination of the policy holders of a large life insurance company. His researches cover two distinct groups: In Group 1 he classes all persons who, up to the beginning of the year 1922, had made several requests for examination (before, during and after the war), and thus had been measured several times. For Group 2 he selected a certain number of newly insured persons from two prewar years and an equal number insured since 1915, and, having separated them into the various age groups, compared them with each other. The average weights and the chest and abdominal measurements vary in a definite, consistent manner with age, and allow certain conclusions to be drawn with respect to the nutrition of the subjects. It was found that the body measurements and weights sagged slowly from 1915 on, and then began gradually to drop more rapidly until the low level of 1918 was reached. From then on, up to the beginning of 1922, the close of the period covered by the research, a gradual rise was noted. However, even at the beginning of the fourth peace year, 1922, the status of 1915 had not been reached. This downward trend till 1918 and upward shoot till 1921 are followed by a new depression for the year 1922. The chest and abdominal measurements run parallel with the weight values. It is interesting to note that, from 1917 on, the falling off in the abdominal measurements is more marked than the decrease of the chest measurements. The year 1918, which, after a long period almost without fats, again brought fats from foreign countries, shows immediately a moderate improvement. From 1919 until 1921 the chest circumference remains the same. The chest, which at first lost its adipose tissue, has now become fixed in its shape through the bones and muscles, and retains its measurements quite firmly. The reactions from changes in diet take place more gradually in the chest than in the abdomen. That was shown plainly in the year 1921, when conditions had improved, for the abdomen approaches its former rotundity, whereas the chest remains still at its low level. The depression of 1922 affected both chest and abdomen, and reduced them to the level of 1918. In considering the high minus values with respect to nutrition that are reached by these researches, it must be borne in mind that the examinees, since they had been accepted by the life insurance company, constituted exceptionally good subjects, for children and aged persons, who are not accepted for insurance, are not included. Then, again, persons carrying life insurance usually live well ordered lives and are in comparatively comfortable circumstances. The decline in the quality of the nutrition, which has been thus statistically established, will of necessity, in the near future, exert a marked influence on the health. Especially the incidence of tuberculosis will likely be increased, since chest development is endangered.

Death of Professor Boruttau

Professor Boruttau, the director of the physiologic laboratory in the municipal hospital at Friedrichshain (Berlin), died recently at the age of 54. It is regrettable to state that this indefatigable investigator took his own life while suffering from an attack of melancholy. Those who knew him well had long been aware of his neuropathic nature. He had inherited psychopathic tendencies from his mother, who died in a psychopathic hospital.

Boruttau was admitted to the University of Göttingen as an instructor, in 1894; received the title of professor in 1899, but on account of a conflict with Professor Verworn in 1907, left Göttingen and assumed charge of the physiologic laboratory as mentioned above. At different times throughout his career, evidences of a supernormal and then again of a subnormal mentality (genius and dementia) manifested themselves. He possessed versatile talents, and his works include physiology, experimental pharmacology, electrotherapy and electrocardiography. He was well versed also in the history of medicine and philosophy, and possessed unusual linguistic ability. Of his larger works, I may mention his "Lehrbuch der Physiologie" and the "Handbuch der gesamten medizinischen Anwendungen der Elektrizität," which he edited in col-

laboration with Professors L. Mann, P. Krause and others. He contributed also a number of articles for Nagel's "Handbuch der Physiologie" and Puschmann's "Handbuch der Geschichte der Medizin."

MADRID

(From Our Regular Correspondent)

April 25, 1923.

Spanish Physician Pleads for German Confrères

Dr. Pulido Martín, on his return from a trip to central Europe, published a plea for aid to the German-speaking physicians, whose sorrows and sufferings touched him deeply. Dr. Pulido shows the difficulties of research work in Germany, where even the feeding of guinea-pigs exceeds the financial resources of scientific institutions. No physician in Berlin can afford to visit his patients in a carriage or automobile; even the most fortunate ride on street cars. Hard work yields barely enough to cover the most pressing needs. Medical students, in order to earn money for expenses, have turned to manual labor, and as they lack the proper training, the number of industrial accidents among these future physicians is enormous. Pulido mentions that even Professor Voelcker of Halle cannot get fuel to heat his home. Israel of Berlin, the kidney surgeon, though now 75 years old, has to work all day after a life devoted to the welfare of mankind. Israel before the war had accumulated a fortune of ten million gold marks and considered himself above the fluctuations of fortune. Dr. Pulido asks the secretary of education to offer inducements to German scientists to turn toward Spanish universities.

The Subconscious

On his admission to the National Academy of Medicine, Dr. R. del Valle y Aldabalde, physician in the Madrid General Hospital and author of many works on nervous diseases, read a paper on the subconscious. Del Valle considers that Avicenna and Schopenhauer were forerunners of Freud in psychanalysis. Avicenna ("Canon," chapter De Ilixi), in describing symptoms, especially the irregular pulse caused by love—which he classifies among mental diseases—says: "In this way it is possible, even though the patient may deny his feelings, to identify the person loved, and to base on this knowledge a mode of treatment. The method consists in repeating certain names while the patient's pulse is being read. As soon as the pulse shows any irregularity, the trial is stopped and one begins again. I have tried this method more than once, and discovered through its use the name of the person loved by the patient." Here is psychanalysis in the eleventh century, even with its sex interpretation. Del Valle also recalled Schopenhauer's words: "If a quarrel, unpleasant news or remembrance is so painful as to become unbearable, then nature itself causes insanity, as a last source of salvation."

Dr. Palacio Valdés, another physician in the general hospital, welcomed the new member and spoke entertainingly on the same subject. Fifty years ago, people considered as subconscious facts, ideas or images which, through continual conscious repetition, have lost their cerebral character and have become automatic, requiring neither intelligence nor attention. Palacio Valdés knows a woman, aged 84, who often does not recognize her own children and is much deteriorated; yet she can play well on the piano.

Ribot has stated that personality is made up by two factors, psychic and somatic, the former originating in the latter, which is the bodily sense or cenesthesia. Pathologic conditions may split these two elements apart and create a dual personality. Palacio Valdés described a woman, aged 28, who was admitted to the psychiatric department of the general hospital a few years ago, suffering from alternating or manic-depressive insanity. This was her third admission to the hospital and she was in a state of depression. This was so pronounced as to pervert her personality and cause a rare and curious syndrome, which is of great interest because of the light it throws on this much debated psychologic problem. The patient spent all night and part of the day lying in bed or on the floor crying. "Are you hurt?" attendants asked her. "No." "Then, why do you cry?" "Because I'm dead and they are going to bury me alive." She persisted with these thoughts for about fifteen days. Some time after her discharge, Palacio Valdés met her on the street. She greeted him and told about her agony in the hospital. "But what made you think you were dead?" he asked her. "Nothing, nothing at all. I felt nothing; and that's what made me think I was dead." "But you knew you were alive," "I did. It is all very strange and inexplicable. I must have been crazy." Palacio Valdés considers this a disintegration of the ego. The patient had lost the vital or bodily sense, her cenesthesia. It was not amnesia, for she must have been able to recall her former life, or she could not have suspected that she was dead. On the other hand, she was afraid of being buried alive. Even in the midst of her derangement she reasoned logically. Her primitive ego, the bodily sense, had disappeared, but her secondary or psychic ego survived. Turning to metaphysics and telepathy, Palacio Valdés told of an old woman who came out on the street one night screaming pathetically and begged help for her son, who was being murdered. The neighbors attributed her excitement to the nervousness of old age. The next day, the boy was found murdered at a spot 3 miles from town. In concluding, Palacio Valdés asserted that the study of subconscious phenomena is now where alchemy and astrology were four centuries ago. Man's intelligence and effort cleared up the mysteries of those early speculations, which have since become chemistry and astronomy. This is a guaranty that the subconscious will be unraveled.

Marriages

WILLIAM MINSTER KUNKEL, Harrisburg, Pa., to Miss Katherine Smoot of Baltimore, June 27.

BENJAMIN A. THOMAS, Philadelphia, to Miss Mabel Eleanor Gray of Merion, Pa., June 19.

NICHOLAS C. STAM, Mason City, Iowa, to Miss Marguerite Reichwine of Chicago, recently.

ERNEST B. ADELMAN, Lynn, Mass., to Miss Matilda M. Lang of Detroit, June 7.

LUTHER W. LOVING, Des Moines, to Miss Ethel Hellenbeck, Laurens, Iowa, recently.

CHESTER J. STURGES, Buffalo, Minn., to Miss Lillian Thompson of Omaha, in June.

RAYMOND SPURZEM, Anoka, Minn., to Miss Mary Hensler of Minneapolis, May 6.

DEAN MCALLISTER LIERLE to Miss Pauline Thompson, both of Iowa City, recently.

LAWRENCE RANDALL, Denison, Iowa, to Miss Faith Meek of Knoxville, recently.

ADOLPH H. AHRENS, St. Paul, to Miss Jane Hayner of Minneapolis, in May.

MACY GINSBURG, Canton, Ohio, to Miss Olive Feldman of Pittsburgh, June 27.

ROBERT M. ALEXANDER to Miss Jessie Smith, both of Reading, Pa., April 19.

OSCAR REISS, Los Angeles, to Miss Edna Jane Bonheim of Chicago, June 16.

NATHAN S. DAVIS III to Miss Cordelia Carpenter, both of Chicago, July 6.

BRUCE MCDOWELL to Miss Ella Powers, both of Hampton, Iowa, recently.

ERNEST MARIETTE to Miss Anna Jones, both of Glen Lake, Minn., June 9.

Deaths

Charles Lincoln Furbush ✠ Philadelphia; Medico-Chirurgical College of Philadelphia, 1893; died, June 26, of arteriosclerosis. Born in New York in 1863, Dr. Furbush in 1898 was appointed acting assistant surgeon of the U. S. hospital ship *Missouri*, in 1899 director of charities and hospitals, Havana, Cuba, and in 1901, acting chief sanitary officer. From 1900-1901 he served in the Philippine Islands. He was delegate to the International Hygiene Exposition, Dresden, Germany, in 1911; director of the Pennsylvania Society for the Prevention of Tuberculosis; a fellow of the College of Physicians of Philadelphia, member of the National Association for the Study and Prevention of Tuberculosis, the American Society of Tropical Medicine, the American Public Health Association and of other organizations. He served as special assistant to Ambassador Gerard in Germany and as military observer with the American Expeditionary Forces in France during the World War. In 1912, Dr. Furbush was appointed a member of the yellow fever commission of the Rockefeller Foundation to Central America. He was awarded the Order of St. George (England) and the Companion Order of St. Michael. Since 1919 he has been director of the department of public health of Philadelphia.

William Malloch Hart, Lieutenant-Colonel, Canadian Army Medical Corps, Ottawa, Ont., Canada; University of Manitoba Faculty of Medicine, Winnipeg, 1907; member of the American Climatological and Clinical Association; formerly connected with the Nopeming Sanatorium, Nopeming, Minn., and the Saskatchewan Sanatorium; served during the World War in France as a private and received the military cross; after his transfer as a prisoner of war he was placed in charge of the Canadian Tuberculosis Hospital, Lenham, England; aged 42; died recently of intestinal obstruction and appendicitis.

Edward Suter Hasell, Victoria, B. C., Canada; L.S.A., London, England, 1884; M.R.C.S., London, England, 1885; member of the British Columbia Medical Association; president of the Vancouver Arts and Crafts Society; one of the founders of the Natural History Society of Victoria; for twenty-six years superintendent of the Provincial Royal Jubilee Hospital; aged 63; died recently.

J. A. Stewart, Montreal, Que., Canada; Queen's University Faculty of Medicine, Kingston, Ont., 1909; formerly on the staff of the Ste. Anne Hospital, Ste. Anne de Bellevue; served in France with the Canadian Army Medical Corps during the World War; surgeon on the Canadian Pacific liner *Melita;* aged 45; died, April 18, at a hospital in Kingston, Ont., following a long illness.

Mahlon Ashbrook Kelso ✠ Enid, Okla.; University of Nebraska College of Medicine, Regular Department, Lincoln, 1887; founder of the Garfield County and the Central Oklahoma medical societies; at one time vice president of the Oklahoma State Medical Association; for many years city physician; aged 66; died, June 13, of myocarditis and chronic nephritis.

William Robert Broughton ✠ New York; Medical Department of Columbia College, New York, 1890; member of the Medical Society of New Jersey; on the staffs of the Mountainside Hospital and the Children's Home, Montclair, N. J.; specialized in ophthalmology; aged 56; died, June 18, at his home in Bloomfield, N. J.

James Reid Sterrett, Durham, N. C.; University College of Medicine, Richmond, Va., 1908; member of the Medical Society of the State of North Carolina; formerly county physician; aged 42; died, June 10, at the Watts' Hospital, West Durham, following an operation for abscess of the lung.

Wilbur Maynard French ✠ Chicago; College of Physicians and Surgeons, Chicago, 1902; formerly instructor of clinical pediatrics at his alma mater and the Illinois Post-Graduate Medical School; on the staff of the University Hospital; aged 47; died, June 22, of strangulated hernia.

Herbert William Turney, Grand Mere, Que., Canada; McGill University Faculty of Medicine, Montreal, 1918; formerly on the staff of the Royal Victoria Hospital, Montreal; physician for the Laurentide Health Service; aged 33; died recently, of heart disease and pneumonia.

Walter Steele McCown, New Market, Ala.; University of Tennessee College of Medicine, Memphis, 1893; member of the Medical Association of the State of Alabama; aged 53; died, June 18, at the City Hospital, Huntsville, of septicemia, following the extraction of a tooth.

William Beauregard Ashburn, South Norfolk, Va.; Medical College of Virginia, Richmond, 1889; member of the Medical Society of Virginia; formerly health officer of Berkley and South Norfolk; physician to the county almshouse; aged 62; died, May 17.

James Pickett, Plainview, Texas; Vanderbilt University Medical Department, Nashville, Tenn., 1882; University of Nashville (Tenn.) Medical Department, 1883; member of the State Medical Association of Texas; aged 70; died suddenly in his office, May 19.

Howard Switzer, Miami, Fla.; Hospital College of Medicine, Medical Department Central University of Kentucky, Louisville, 1884; member of the Florida Medical Association; past president of the Dade County Medical Society; aged 73; died, May 22.

Edgar Mead Reading ✠ Chicago; Bennett Medical College, Chicago, 1877; formerly emeritus professor of neurology, Loyola University School of Medicine; aged 70; died, June 27, at Berrien Springs, Mich., of uremia and dilatation of the heart.

Henry Elmer Center, Plattsburg, N. Y.; University of Vermont College of Medicine, Burlington, 1886; member of the Medical Society of the State of New York; aged 61; died, June 12, at the Physicians' Hospital, of diabetes and heart disease.

Benjamin Gannaway Allison, Middlesboro, Ky.; Lincoln Memorial University Medical Department, Knoxville, Tenn., 1917; member of the Kentucky State Medical Association; aged 46; died, June 16, of a bullet wound, self-inflicted.

Henry DeWolfe Carvelle ✠ Manchester, N. H.; Medical School of Harvard University, Boston, 1878; specialized in ophthalmology and otology; on the staff of the Elliott Hospital; aged 71; died, June 2, of embolism.

Horace Byron Williams, Detroit; Michigan College of Medicine and Surgery, Detroit, 1900; member of the Michigan State Medical Society; aged 48; died, June 2, at St. Mary's Hospital, following a long illness.

John Kemp Warfield Piper, Russellville, Ky.; University of Maryland School of Medicine, 1893; member of the Kentucky State Medical Association; aged 52; died, June 12, at Phoenix, Ariz., of pneumonia.

Edward McLaughlin, Morrisburg, Ont., Canada; Queen's University Faculty of Medicine, Kingston, 1886; medical officer of the Canadian National Railway; aged 69; died, April 17, of pneumonia.

Meldrum Burley Floyd, Dayton, Ohio; University of Michigan Medical School, Ann Arbor, 1903; formerly city bacteriologist; member of the Ohio State Medical Association; aged 46; died, June 9.

Walter S. Bray, Camden, N. J.; Jefferson Medical College of Philadelphia, 1887; member of the Medical Society of New Jersey; on the staff of the Cooper Hospital, where he died, June 9, aged 60.

Arthur D. H. Thrane, Eau Claire, Wis.; Rush Medical College, Chicago, 1868; member of the State Medical Society of Wisconsin; aged 79; died, June 15, at the Sacred Heart Hospital, of senility.

Eugene R. Waterhouse, St. Louis; Eclectic Medical Institute, Cincinnati, 1884; American Medical College, St. Louis, 1889; aged 73; died, June 2, of chronic nephritis and arteriosclerosis.

Willmar Horace Thorwaldson, Chicago; Northwestern University Medical School, Chicago, 1922; intern at the Wesley Memorial Hospital; was drowned, June 24, near Elgin, Ill.

Eugene Holt Eastman, Chicago; Hahnemann Medical College and Hospital, Chicago, 1903; aged 52; died, June 4, at the Washington Boulevard Hospital, of carcinoma of the liver.

Isabelle F. Orr Williams, Bethany, Okla.; College of Physicians and Surgeons, Medical Department Kansas City University, Kansas City, Kan., 1903; aged 64; died, June 3.

Jepson F. London, St. John, N. B., Canada; McGill University Faculty of Medicine, Montreal, Que., 1908; aged 45; died recently, at the General Public Hospital.

William Burrette Kitchen ✠ Indianapolis; Medical College of Indiana, Indianapolis, 1903; aged 49; was found dead in his office, June 20, of cerebral hemorrhage.

✠ Indicates "Fellow" of the American Medical Association.

Calvin Rupert Atkins, Indianapolis; Howard University School of Medicine, Washington, D. C., 1898; aged 53; was shot and killed by an insane man, June 13.

Albert R. Lusty, Britton, Mich.; Detroit College of Medicine and Surgery, 1897; aged 57; died, May 25, at the Harper Hospital, Detroit, following a long illness.

Charles Montague Noble, Peoria, Ill.; College of Physicians and Surgeons, Chicago, 1901; aged 49; died, June 23, at the Proctor Hospital, of heart disease.

Lewis Warner Beck, Los Angeles; Bennett College of Eclectic Medicine and Surgery, Chicago, 1886; aged 91; died, May 31, at Garnett, Kan., of paralysis.

George Willard Libby ✠ Spokane, Wash.; Medical School of Maine, Portland, 1876; aged 73; died, June 6, at the Deaconess Hospital, of heart disease.

Peter Douglas Hilty ✠ Birmingham, Mich.; Detroit College of Medicine and Surgery, 1908; aged 44; died suddenly in church, June 10, of heart disease.

Charles Edgar Diven, Anderson, Ind.; Miami Medical College, Cincinnati, 1874; aged 72; died, June 11, at St. John's Hospital, of cerebral hemorrhage.

John F. Chapin, Schoolcraft, Mich.; University of Vermont College of Medicine, Burlington, 1861; aged 85; died suddenly, June 13, of senility.

Joseph W. Renfro, Sharpsburg, Ky.; University of Louisville (Ky.) Medical Department, 1878; aged 60; died, April 27, of cerebral hemorrhage.

Robert C. Hamilton, Chicago; Physio-Medical Institute, Cincinnati, 1882; aged 76; died, June 16, at Kansas City, Mo., following a prostatectomy.

Edmond B. Curd, New Providence, Ky.; University of Louisville (Ky.) Medical Department, 1870; aged 82; died, April 22, of heart disease.

William L. Wharton, Matthews, Ind.; Medical College of Indiana, Indianapolis, 1882; aged 71; died, June 2, at the Home Hospital, Muncie.

Edwin Sterrett Dodds, Seattle; Miami Medical College, Cincinnati, 1879; member of the board of health; aged 74; died suddenly, June 3.

David Henry McKenzie, Leadwood, Mo.; Kentucky School of Medicine, Louisville, 1896; aged 60; died, April 28, of cerebral hemorrhage.

John Robinson Stone, Parry Sound, Ont., Canada; University of Toronto Faculty of Medicine, Toronto, 1889; aged 55; died, April 26.

Charles Albert Higinbotom, Vandalia, Ill.; Eclectic Medical Institute, Cincinnati, 1883; aged 60; died, June 6, of pyelonephritis.

Stephen Witt, North Dana, Mass.; Eclectic Medical Institute, Cincinnati, 1878; aged 83; died, June 3, of cerebral hemorrhage.

E. S. Baker, Madisonville, Ky.; University of Tennessee College of Medicine, Memphis, 1885; aged 81; died, April 17, of senility.

Aaron Puderbaugh, Ozawkie, Kan.; Kansas City (Mo.) Medical College, 1882; aged 85; died, June 1, in Kansas City, of senility.

Benjamin Franklin Berry, Nevada, Mo.; University of Louisville (Ky.) Medical Department, 1880; aged 74; died, April 11.

Jacques Augustin Leblanc, Montreal, Que., Canada; Montreal School of Medicine and Surgery, 1879; aged 69; died recently.

Frederic Henry Grant ✠ New York; Medical Department of Columbia College, New York, 1890; aged 63; died, June 2.

Andrew Browne Evans, Jr., Church View, Va.; Southern Medical College, Atlanta, Ga., 1892; aged 50; died recently.

Edward York Bass, Tulsa, Okla.; University of Nashville (Tenn.) Medical Department, 1892; aged 56; died, June 5.

James W. Barrett, Osage, Iowa; Hahnemann Medical College and Hospital, Chicago, 1879; aged 69; died, June 18.

Walter Roberts, Wooldridge, Mo.; Bellevue Hospital Medical College, New York, 1893; aged 54; died recently.

Julius Wiltschek, Dallas, Texas (licensed, years of practice); also a druggist; aged 75; died, May 29.

Daniel B. Campbell, Old Monroe, Mo.; St. Louis (Mo.) Medical College, 1873; aged 78; died recently.

Vito Beneventi, Chicago; University of Naples, Italy, 1896; aged 58; died, June 25.

Correspondence

"THE VALUE OF THE TOXIN OF RHUS TOXICODENDRON AND RHUS VENENATA"

To the Editor:—In THE JOURNAL, June 2, p. 1588, is an article by Dr. Albert Strickler on "The Value of the Toxin (Antigen) of Rhus Toxicodendron and Rhus Venenata." This material is considered in its relation to treatment during the attack and to immunization. A table of cases treated by thirty-five physicians sets forth the records of 356 patients, though nineteen of the physicians reported less than five cases each. "In the vast majority of cases, improvement was noted twenty-four hours after the institution of this mode of treatment." In the second paragraph of the "comment," bearing on desensitization, occurs the statement, "It is incapable of doing harm." With this remark I beg to differ. In the early summer of 1921, a medical student came to the Jefferson Hospital Skin Dispensary with this history: He had had an attack of dermatitis venenata and had been treated by Dr. Strickler. After the complete subsidence of the outbreak, his medical attendant suggested that he allow himself to be immunized against the disease. The injection method was used, three doses being given. A typical, almost universal, eruption of dermatitis venenata broke out promptly, and it was nearly four weeks before it had again disappeared. There had been no further exposure to the plant. A short series of cases in our dispensary and private practice, using this preparation with Strickler's dosage and intervals, was very disappointing, as the progress of the cases was not checked and most of the patients were rendered appreciably worse. Several patients refused treatment after the second injection. Five-tenths cubic centimeter intramuscularly gave them considerable pain, and an anaphylactic eruption of an urticarial nature developed, being especially marked about the site of the injection. The dermatitis was not favorably affected by the injections.

EDWARD F. CORSON, M.D., Philadelphia.

[This letter was referred to Dr. Strickler, who replies:]

The experiences which Dr. Corson relates are based on five or six cases which he states he has either treated or seen treated, and the majority of these patients were lost from observation after the second injection had been given them.

In the article I stated that while the large percentage of patients suffering from dermatitis venenata due to poison ivy or poison oak are relieved in twenty-four hours, a certain number of them are not relieved until forty-eight hours after treatment is instituted. It is therefore very clear that Dr. Corson has practically no criteria by which to judge the merits or demerits of the method of treatment which I advocate.

I am fully cognizant of the facts in the case of the Jefferson medical student, treated by me for dermatitis venenata, presumably due to poison ivy. This case was seen in the summer of 1921, and the true facts of the matter are as follows: This patient gave a history of marked susceptibility to poison ivy, and when I saw him, at the suggestion of Dr. Thomas McCrae, he presented a vesicular eruption between the fingers of both hands which, while not absolutely typical of dermatitis venenata, yet, taken together with his history, was suggestive enough to warrant treatment. He was given three injections which did not produce a cure but did cause a modification of the eruption, and I recorded his case as one of the failures in the series which I reported.

I wish to state emphatically that this treatment is not fool-proof, and is offered to the profession either for its

praise or condemnation, whichever a prolonged experience may show. In the experiences of the numerous physicians who have used the toxin (antigen) method and who, very kindly, have assisted in gathering the statistics published, not one instance was noted in which harm has resulted from the employment of the toxin (antigen) method, nor do I know of a single instance in which an attack of dermatitis venenata has resulted from the employment of the remedy.

When this toxin (antigen) is injected subcutaneously and not intramuscularly, it is capable of producing a localized reaction consisting of erythema and swelling, which is probably the anaphylactic phenomenon to which Dr. Corson refers. I have stated very clearly and emphatically that the toxin (antigen) is to be injected intramuscularly. It is also to be stated that, owing to the alcoholic content of this preparation, the injection is somewhat painful, but only for three or four minutes after the injection, and produces a redness and swelling of the areas where the injection is given. The extent of these inflammatory phenomena depends on the amount of the preparation administered.

I am extending to Dr. Corson the use of a reasonable quantity of this toxin (antigen), gratis, for use in the treatment of cases of dermatitis venenata, provided accurate records of the cases treated will be kept and a true value of the remedy established.

Unjust and hasty criticisms and criticisms based on illusionary grounds are greatly to be regretted, as they are capable of producing false impressions, and deter the profession from using a remedy which shows every evidence of being a successful therapeutic method.

ALBERT STRICKLER, M.D., Philadelphia.

"TREATMENT OF BILHARZIASIS"

To the Editor:—In Queries and Minor Notes (THE JOURNAL, June 23, p. 1868), emetin was mentioned as a recent treatment for bilharziasis. I worked for five years with intravenous experiments against *Bilharzia haematobia* in the Greek Hospital at Cairo, Egypt, and in 1915-1916 I was first to inject emetin in the veins of infected patients. Since then my colleagues there have been using the injection freely with moderate success.

My experience shows that emetin or the new treatment with antimony and potassium tartrate is useful, but neither drug kills the parasite (*Distoma haematobium*) because we cannot use large enough doses. The fact remains that the parasite dies in about five years, if no reinfection takes place and if the patient lives under good hygienic conditions.

JOHN REGUZIS, M.D., New York.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

INTRACUTANEOUS TEST FOR VIRULENCE OF DIPHTHERIA BACILLI—SCHULTE-TIGGES METHOD OF STAINING TUBERCLE BACILLI

To the Editor:—1. What is the technic for performing the skin virulence test for diphtheria? Can it be done with mixed throat cultures? 2. What is the technic employed in performing the Schulte-Tigges stain for tubercle bacilli as discussed in a recent issue of the *Journal of Bacteriology?* Please omit my name. W. W.

ANSWER.—1. Intracutaneous injections in guinea-pigs of suspected bacilli can be used in order to determine whether or not they are virulent. Zingher and Zoletsky (*J. Infect. Dis.* **27**:54, 1916) recommend the following modification of Neisser's original method: The skin of the abdomen of two guinea-pigs, each weighing about 250 gm., is shaved: a twenty-four hour culture of diphtheria bacilli on Loeffler's medium is suspended in 20 c.c. of salt solution, of which 0.15 c.c. is injected intracutaneously at the corresponding place of the two guinea-pigs; one of the animals, the control, receives 250 units of antitoxin by injection into the heart, or, if possible, it is still better to have it prepared beforehand by intraperitoneal injection of antitoxin twenty-four hours earlier. In this way as many as six cultures may be tested on two animals. Virulent bacilli produce a circumscribed infiltration followed by superficial necrosis in two or three days, whereas the skin in the control animal is unchanged. Whether this test can be used with satisfactory results with mixed throat cultures we are unable to say, but it seems likely that bacteria other than the diphtheria bacillus might cause local and general complications that would interfere with the reliability of the results.

The intracutaneous guinea-pig test for human susceptibility to diphtheria was discussed in THE JOURNAL by Kellogg (May 12, 1923, p. 1399) and by Zingher (June 23, 1923, p. 1867).

2. According to the Schulte-Tigges method of staining tubercle bacilli, the slide is flooded with carbolfuchsin (10 c.c. of saturated solution of basic fuchsin in 95 per cent. alcohol, and 90 c.c. of 5 per cent. phenol [carbolic acid]).

The slide is heated to steaming, and the heating is continued for one minute. Excessive heating should be avoided. the excess stain is washed off with tap water, and the slide decolorized in sodium sulphite (10 per cent. aqueous solution of sodium sulphite). This solution should be renewed at least once a week and, if convenient, twice a week. The slide is washed thoroughly with tap water, and counterstained with picric acid (saturated aqueous solution of picric acid). It is then washed with tap water, dried and examined. The tubercle bacilli are red; the background is pinkish yellow.

Shoub (*J. Bacteriol.* **8**:121 [March] 1923) concludes that the Schulte-Tigges method of staining is not more difficult that the Ziehl-Neelson method, but is easier. It gives about 33 per cent. more positives, and it does away with the use of alcohol.

FRIEDLÄNDER'S BACILLUS INFECTION

To the Editor:—For the last three years I have had an infection of the larynx with the bacillus of Friedländer. It started, no doubt, from an ethmoiditis of mixed infection, as the discharge from this contains the germ. However, the laryngitis is now the most troublesome, and anything short of surgical treatment to the ethmoiditis does not help the larynx much. During the winter, I tried the seaside for a month and with a cold the condition became more a tracheitis than before. I have had advice from good specialists, but am still wondering whether there is any way to attack this germ more effectively. Please omit my name. E. P.

ANSWER.—As far as we are aware, there is no specific treatment for Friedländer's bacillus infection. Laryngitis or tracheitis may be due to a paranasal infection, often an ethmoiditis. The only successful method of combating the secondary trouble is to relieve the primary one, namely: the ethmoiditis. Sometimes conservative measures, such as infraction of the middle turbinate away from the lateral wall, will give better drainage to the ethmoids, or the removal of the anterior tip of the middle turbinate will suffice. If this, together with suction, does not give the desired relief, it may be necessary to do either a simple or a more radical ethmoid operation. The local application of an astringent, such as 5 per cent. zinc phenolsulphonate solution, in the larynx may have some sedative effect. However, the chronic laryngitis will not be definitely relieved until the nasal or nasopharyngeal infection is overcome.

PIGMENT IN AREOLA

To the Editor:—Is it possible for a woman to have pigmentation around the nipples without ever having been pregnant, or is that an absolute sign of a former pregnancy? If such a thing is possible, what conditions cause it? Please omit my name. M. S.

ANSWER.—The amount of pigment in the areola varies greatly in different women. In brunettes there may be a great deal of pigment normally. It is true that pigmentation here and elsewhere also usually increases in pregnancy, but it is not absolutely characteristic of pregnancy because sometimes it develops in association with tumors of the reproductive organs.

Medical Education, Registration and Hospital Service

COMING EXAMINATIONS

ALABAMA: Montgomery, July 10-13. Chrm., Dr. Samuel W. Welch, Montgomery.

CALIFORNIA: San Francisco, July 9-12. Sec., Dr. Charles B. Pinkham, 908 Forum Bldg., Sacramento.

CONNECTICUT: New Haven, July 10. Sec. Electic Board, Dr. James E. Hair, 730 State St., Bridgeport. Sec. Homeo. Board, Dr. E. C. M. Hall, 82 Grand Ave., New Haven.

CONNECTICUT: Hartford, July 10-11. Sec., Dr. Robert L. Rowley, 79 Elm St., Hartford.

DISTRICT OF COLUMBIA: Washington, July 10-12. Cec., Dr. Edgar P. Copeland, 104 Stoneleigh Court, Washington.

HAWAII: Honolulu, July 9-12. Sec., Dr. G. C. Milner, 401 Beretania St., Honolulu.

INDIANA: Indianapolis, July 10. Sec., Dr. Wm. T. Gott, Crawfordsville.

MAINE: Augusta, July 10-11. Sec., Dr. Adam P. Leighton, Jr., 192 State St., Portland.

OKLAHOMA: Oklahoma City, July 10-11. Sec., Dr. J. M. Byrum, Shawnee.

PENNSYLVANIA: Philadelphia and Pittsburgh, July 10-14 Preliminary Examiner, Mr. C. D. Koch, 422 Perry Bldg., Philadelphia.

PHILIPPINE ISLANDS: Manila, August 14. Sec., Mr. José V. Gloria, 400 Asuncion, Manila.

SOUTH DAKOTA: Deadwood, July 17. Dir., Dr. H. R. Kenaston, Bonsteel.

WEST VIRGINIA: Martinsburg, July 10. Sec., Dr. W. T. Henshaw, Charleston.

REPORT OF THE FIFTEENTH EXAMINATION OF THE NATIONAL BOARD OF MEDICAL EXAMINERS

The fifteenth examination of the National Board of Medical Examiners was held in twenty-four Class A medical schools, Feb. 12, 13 and 14, 1923, in Part I, which comprises written examinations in each of the six fundamental medical sciences. The subjects of the examination and the relative value of each were: anatomy, 100; physiology, 75; materia medica and pharmacology, 75; pathology, 75; physiologic chemistry, 50, and bacteriology, 50, making a total of 425 counts for this part.

A candidate taking Part I must earn at least 75 per cent. of this total. The number of counts earned in any subject depends directly on the ratings of the answered papers. Falling below 65 per cent. in two subjects or below 50 in one subject constitutes a failure.

A candidate is allowed to take an incomplete examination, omitting one of the subjects, if the instruction in this subject is not completed in the medical school of attendance by the end of the second year.

One hundred and thirty-five candidates appeared for examination in Part I; of these, 112 passed, five took an incomplete examination, and eighteen failed to pass the examination.

EXAMINATION, PART I

ANATOMY

Answer eight questions out of the ten. 1. Make a series of diagrams showing the size and form of human embryos of the following ages: twenty days; thirty days; ninety days. 2. Discuss the amnion, chorion and allantois in the human: structure; relation; function. 3. Name the various kinds of epithelium found in the urinary tract. 4. Describe the blood corpuscles, giving relative numbers, sizes, functions, etc. 5. Describe briefly the gastro-intestinal tract, and illustrate the variations of the mucous membrane in the various parts. 6. Name the muscles concerned with inversion and eversion of the foot, and tell how these muscles are affected by flatfoot or fallen arch. 7. Indicate in a diagram the topography of the lungs, and state the main differences in size and shape between the right and left lungs. 8. Draw diagrams showing a midsagittal section of the pelvis in the male and in the female. Label fully. 9. Enumerate and locate the various types of sensory end-organs found in man. 10. Make a diagram of the cerebral cortex, showing the principal motor areas.

PHYSIOLOGY

Answer any five of the following questions: 1. Discuss the present knowledge of the function of the adrenal glands. 2. Compare the various responses of smooth and striated muscle to various types of stimuli. 3. Discuss the gaseous exchanges (*a*) through the lungs, and (*b*) between the blood and tissues. 4. Outline the main factors upon which arterial blood-pressure depends. 5. Define (*a*) basal metabolism; (*b*) direct and indirect calorimetry; (*c*) specific dynamic action of protein; (*d*) hypoglycemia. 6. Give one method of detecting (*a*) astigmatism; (*b*) myopia; (*c*) heterophoria.

PHYSIOLOGIC CHEMISTRY

Answer any five questions. 1. Define (*a*) molar solution; (*b*) normal solution; (*c*) a catalyst; (*d*) a buffer solution; (*e*) the *p*H. 2. State briefly the requirements for an adequate diet. 3. A healthy adult at rest is given an adequate diet containing 118 grams of protein, and the urine for a twenty-four hour period is analyzed. Give the approximate figures which will be obtained for the total urinary nitrogen and its distribution among the various nitrogenous constituents of the urine. 4. Discuss the buffer systems acting to maintain constancy of reaction in mammalian blood. 5. Discuss the disturbance of fat metabolism which occurs when there is an inadequate combustion of carbohydrate. 6. What are the sources of uric acid in the urine? What is the concentration of uric acid in normal human blood? 7. What is glycogen, and what part does it play in carbohydrate metabolism? 8. How would you determine that the reduction of Fehling's solution by a urine was not due to glucose? What other substances may occur in the urine which will reduce Fehling's solution? 9. What is the concentration of blood-sugar (*a*) in the normal fasting adult? (*b*) in the normal adult after an average meal? At what level of blood-sugar concentration does glucose usually appear in the urine?

PATHOLOGY

Answer five questions from the following: 1. Discuss the pathology of myxedema. 2. Discuss focal necroses of the liver. 3. Discuss the pathology of tuberculosis of the peritoneum. 4. Give the differential pathologic diagnosis of new growths of the uterus. 5. Discuss the pathology of tumors of the long bones. 6. Give the theories of the formation of renal calculi. 7. Outline the necessary necropsy technic in a case of suspected poisoning by mouth.

BACTERIOLOGY

Answer any five of the following questions. 1. (*a*) Given a patient with a sore on the genitalia that had existed for *not more than one week*, describe briefly the laboratory diagnostic methods employed to determine whether or not it is a primary syphilitic lesion. What precautions must be observed in securing the material for examination? (*b*) Are complement-fixation tests of any diagnostic value during the stage mentioned in subparagraph (*a*), and, if so, from what part of the patient's body would you procure the material for making the test? (*c*) Given a patient with a chronic but slight discharge from the urethra and without visible signs of acute inflammatory reaction, how would you obtain proper material for microscopical examination, and what findings would lead you to conclude that the case was one of chronic gonorrhea? 2. (*a*) How does the meningococcus gain entrance into the body, and from what body fluids may it be recovered by cultural methods? (*b*) Given a patient suspected of having epidemic cerebrospinal meningitis with symptoms which have existed for only twenty-four hours, name the laboratory methods which you would employ to confirm the diagnosis. (*c*) Given a patient suspected of having epidemic cerebrospinal meningitis in the third or fourth day of illness, describe the diagnostic laboratory tests which you would employ (exclusive of cultural methods) in making the diagnosis, and the findings upon which you would base a positive diagnosis. 3. Discuss the diagnosis by laboratory methods of an individual suspected of having tuberculosis of the kidney. 4. (*a*) Name four of the more common round worms (nematodes) that infest man in the United States, and indicate the geographical distribution of each species in the United States. (*b*) Name four of the more common tapeworms (cestodes) that infest man in the United States, and indicate the geographical distribution of each species in the United States. (*c*) Draw an outline diagram of the following ova as they appear when seen under the microscope: hookworm (*N. americanus*); round worm (*A. lumbricoides*); whip worm (*T. trichuria*); dwarf tapeworm (*H. nana*). 5. (*a*) Discuss serum-sickness and the precautions which should be taken to prevent serum-sickness. (*b*) In what diseases are agglutinin reactions of practical value? Discuss briefly the diagnostic value of agglutination reactions in the diagnosis of typhoid and paratyphoid fevers in the light of specific preventive measures now in general use throughout the United States. 6. (*a*) How would you perform the "presumptive test" for colon bacilli in the examination of water supplies for potability? (*b*) On what finding would you condemn the water supply for drinking purposes from the bacteriological point of view? 7. (*a*) Discuss the chief points of differentiation, under the microscope, between a stained tertian malarial parasite three-fourths grown and a stained quartan parasite three-fourths grown. (*b*) How would you stain a freshly prepared blood-smear for the demonstration of malarial parasites? 8. Given sputum from a patient with lobar pneumonia, how would you isolate pneumococci in pure culture, and how would you determine the type of pneumococcus found?

MATERIA MEDICA AND PHARMACOLOGY

Answer all questions. 1. (*a*) Give the source of nux vomica, three medicinal preparations, and dosage of each. (*b*) Give the incompatibilities of the salts of strychnin. (*c*) Discuss the action of strychnin on the brain and spinal cord. 2. (*a*) Discuss the action of morphin on the respiratory center. (*b*) Explain the constipating effect of opium. 3. (*a*) What is understood by the digitalis series or digitalis bodies? (*b*) What is meant by the active principles of digitalis? (*c*) Describe the action of digitalis on the frog's heart. 4. (*a*) Discuss the general pharmacologic actions of the nitrites. (*b*) Name three medicinal preparations of this group, and give the dosage of each. 5. Discuss the pharmacologic actions of quinin. 6. Discuss the pharmacologic actions of the extract of the posterior lobe of the pituitary body.

PART II

Part II of the examination was held in fifteen medical schools, February 15 and 16. This was also a written examination in the following subjects and with the relative values assigned: medicine, 75; surgery, 75; obstetrics and gynecology, 50; and public health, 25, making a total of 225 counts for this part. A candidate taking Part II must earn at least 75 per cent. of this total. The number of counts earned in any subject depends directly on the ratings of the answered papers. Falling below 65 per cent. in two subjects or below 50 in one subject constitutes a failure.

Twenty-eight candidates appeared for examination in Part II. Of these, twenty-six passed and two failed.

Names and Colleges	PASSED, PART II	Year of Graduation
Ethel Fanson, College of Medical Evangelists		1921
Sung-Tao Kwan, Rush Medical College		1923
Temple S. Fay, Univ. of Pennsylvania Medical School		1921
Frederick A. Bothe, Univ. of Pennsylvania Medical School		1921

Alvin R. Hufford, Univ. of Loyola Medical College	1922
Elizabeth A. Kittredge, Johns Hopkins Medical School	1922
Alexander Margolies, Univ. of Pennsylvania Medical School	1921
Loren R. Chandler, Stanford University Medical School	1921
Richard Dresser, Johns Hopkins Medical School	1921
Malcolm Thompson, Univ. of Pennsylvania Medical School	1922
Ralph W. Elston, Rush Medical School	1923
John F. Bacon, Univ. of Pennsylvania Medical School	1922
Charles E. Constantine, Harvard Medical School	1922
Emily Van Loon, Woman's Medical College	1922
Harold J. Thompson, Rush Medical College	1922
Norman W. Loud, Harvard Medical School	1919
Charles Ferguson, Univ. of Oregon Medical School	1922
Everett E. Angle, Harvard Medical School	1921
Bernard J. McCloskey, Univ. of Pennsylvania Medical School	1922
Karl Schlaepfer, University of Zurich	1914
Carl Benson, University of Buffalo Medical School	1922
Dohrmann K. Pischel, Stanford Univ. Medical School	1922
Joseph Blalock, Johns Hopkins Medical School	1922
Howard M. Freas, University of Pennsylvania Medical School	1921
A. T. Morrison, Univ. of Oregon Medical School	1922
Doris Tuttle, Woman's Medical College	1922

FAILED

Boston University Medical School	1922
Woman's Medical School	1922

EXAMINATION, PART II

MEDICINE

Answer six questions, including the first four and two selected from questions 5 to 8. Read the questions carefully and answer concisely what is asked. Plan your time so that the answers to all six questions may be completed within three hours. Quality will count more than quantity in marking the answers, and an intelligent understanding of the disease more than a mere array of memorized facts. File a printed copy of the questions with your examination paper; this makes it unnecessary to copy the questions when writing your answers. 1. (*a*) Describe a typical attack of rheumatic fever of moderate severity. (*b*) Treatment of this case. (*c*) Name the one other condition with which, in your opinion, rheumatic fever is most likely to be confused, and state the diagnostic points which would aid in differentiation. 2. (*a*) Discuss the relation of alcohol to cirrhosis of the liver. (*b*) Give the diagnostic signs whose presence would warrant the diagnosis of cirrhosis of the liver. (*c*) Treatment. 3. (*a*) Define pulmonary emphysema. (*b*) Give the physical signs of a typical case in a laboring man of sixty years. (*c*) Discuss the probable etiology. (*d*) How would you treat the case? 4. (*a*) Define dementia praecox. (*b*) Describe briefly its usual course. 5. Discuss the etiology and characteristic clinical picture of subacute bacterial endocarditis. 6. Mention (*a*) the diseases associated with marked enlargement of the spleen, and in each instance (*b*) the usual degree of enlargement, and (*c*) the chief associated diagnostic signs. 7. How does inflammation of the lung caused by the pneumococcus differ (*a*) in infants, and (*b*) in young children, from the same infection in adults? 8. Describe the symptoms, physical signs and course of Parkinson's disease.

SURGERY

Answer any five questions. 1. Give the symptoms (briefly) of tumor of the brain. What complications may arise demanding immediate surgical relief. 2. Give the indications for and describe your method of choice of performing a tracheotomy. 3. (*a*) Describe the direct and indirect methods of performing cardiac massage. (*b*) Discuss in addition to cardiac massage other measures used in resuscitation. 4. Give symptoms, diagnosis, differential diagnosis, prognosis and treatment of acute perforated ulcer of the duodenum. 5. (*a*) Give the indications for amputation of the thigh at the middle third. (*b*) Discuss fat embolism. 6. Discuss (briefly) the surgical management of infection (*a*) locally (*b*) general.

OBSTETRICS

Answer all questions. 1. What are the causes and outline the management of a prolonged first stage of labor? 2. Describe briefly the clinical history and pathologic lesions of the fetus and placenta in syphilis. 3. Give a classification of contracted pelvis, and describe in detail the mechanism of labor in a simple flat pelvis in a vertex presentation. 4. Give clinical history, diagnosis and management of a typical case of toxemia of pregnancy during the last few weeks of pregnancy. 5. Discuss the pathogenesis, symptoms and differential diagnosis of acute pyelitis complicating pregnancy.

GYNECOLOGY

Answer all questions. 1. Technic of supravaginal hysterectomy for fibroids, including the preparation and after-care of the patient. 2. Clinical history and diagnosis of tubal pregnancy (*a*) before and (*b*) after rupture. 3. What are the ordinary causes, and describe the treatment of hemorrhage from the nonpregnant uterus? 4. Describe three varieties of ovarian tumors, and give the differential diagnosis of each variety. 5. Discuss the physiology of the corpus luteum and its therapeutic uses.

PUBLIC HEALTH

HYGIENE

Answer all questions. 1. What are the important sources and agencies of infection in typhoid fever, in cholera and in yellow fever? 2. Name three common important infectious diseases of unknown origin found in the United States and discuss the prevention of each. 3. What measures should health officers employ for the prevention of a threatened epidemic of influenza? 4. What do you understand by "vitamins"? Name two, giving the source of each. Discuss their significance from the point of view of nutrition. 5. What can be done to reduce the morbidity from heart disease and from nephritis?

MEDICAL JURISPRUDENCE

Answer all questions. 1. What symptoms would lead you to suspect acute arsenic poisoning; chronic arsenic poisoning; acute belladonna poisoning? 2. Discuss the civil and legal relations of insanity. 3. Discuss the relative value of microscopical, chemical and serological tests for the determination of the source of suspected blood stains. 4. What are the risks associated with smallpox vaccinations, and what are the limitations of vaccination in the control of the disease?

District of Columbia January Examination

Dr. Edgar P. Copeland, Secretary, District of Columbia Board of Medical Supervisors, reports the oral and written examination held at Washington, Jan. 9-11, 1923. The examination covered 16 subjects and included 80 questions. An average of 75 per cent. was required to pass. Five candidates were examined, all of whom passed. Four candidates were licensed by reciprocity. The following colleges were represented:

College	PASSED	Year Grad.	Per Cent.
Georgetown University		(1916)	86
George Washington University		(1922)	85.6
Johns Hopkins University		(1919), (1920)	81
University of Michigan		(1918)	79.8

College	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
College of Physicians and Surgeons, Baltimore		(1882)	Georgia
University of Maryland		(1912)	Maryland
Pulte Medical College		(1887)	Ohio
University College of Medicine, Richmond		(1913)	Virginia

Minnesota April Examination

Dr. Thomas S. McDavitt, secretary, Minnesota State Board of Medical Examiners, reports the oral, written and practical examination held at Minneapolis, April 3-5, 1923. The examination covered 15 subjects and included 80 questions. An average of 75 per cent. was required to pass. Nine candidates were examined, all of whom passed. Seventeen candidates were licensed by reciprocity. The following colleges were represented:

College	PASSED	Year Grad.	Per Cent.
Rush Medical College		(1923)*	89, 92, 92
University of Minnesota Medical School		(1923)†	91, 91.8
University of Oregon		(1922)	91
University of Toronto		(1915)	91.5
Queen's University of Belfast, Ireland		(1921)	92.7
University of Rostock, Germany		(1911)	89.1

College	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
Georgetown University		(1920)	Michigan
Loyola University		(1921)	Illinois
Rush Medical College		(1917) (1923)	Illinois
State University of Iowa College of Medicine		(1907) (1920), 1921)	N. Dakota Iowa
Tulane University		(1919)	Louisiana
Baltimore Medical College		(1903)	California
Harvard University		(1918)	Penna.
University of Michigan Medical School		(1921)	Michigan
John A. Creighton Medical College		(1921)	Kansas
Medical College of Ohio		(1907)	Ohio
University of Pennsylvania	(1918) Pennsylvania,	(1920)	N. Carolina
University of Virginia		(1919)	Virginia
McGill University		(1905)	N. Dakota

* These candidates have finished their medical courses and will receive their M.D. degrees on completion of their internships.

† These candidates have finished their medical courses and received their M.B. degrees; they will receive their M.D. degrees on completion of their internships.

West Virginia January Examination

Dr. W. T. Henshaw, state health commissioner, West Virginia Public Health Council, reports the oral, written and practical examination held at Charleston, Jan. 9-10, 1923. The examination covered 11 subjects and included 110 questions. An average of 80 per cent. was required to pass. Of the 3 candidates examined, 2 passed and 1 failed. Ten candidates were licensed by reciprocity. The following colleges were represented:

College	PASSED	Year Grad.	Per Cent.
University of Maryland		(1915)	93.4
Medical College of Virginia		(1922)	90.5

FAILED

University of Lille, France		(1902)*	57.3

College	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
Loyola University		(1916)	Illinois
Northwestern University		(1918)	Illinois
University of Louisville		(1913)	Kentucky
Kentucky University		(1905)	Indiana
Tulane University		(1915)	Mississippi
Johns Hopkins University		(1916)	Maryland
University of Maryland		(1920)	Maryland
Central Medical College of St. Joseph		(1897)	Illinois
Medical College of Ohio		(1890)	Indiana
Medical College of Virginia		(1915)	Virginia

* Graduation not verified.

Book Notices

ULTRAVIOLET RADIATION: ITS PROPERTIES, PRODUCTION, MEASUREMENT AND APPLICATIONS. By M. Luckiesh, Director of Applied Science, Nela Research Laboratories, National Lamp Works of General Electric Co. Cloth. Price, $3.50 net. Pp. 258, with 12 illustrations. New York: D. Van Nostrand Company, 1922.

More than three and a half centuries ago, Newton discovered the spectrum; but he saw only the visible radiations: he had no means of learning that, beyond the violet edge, ultraviolet radiation was impinging, and that, beyond the red edge, infra-red radiation was present. Yet these and other radiations differ physically only in wave-lengths and frequency of vibration from the relatively small radiations visible to the naked eye. And this science of the invisible rays is relatively recent, but so important that it is becoming commonplace in medicine. In view of this, the book by Luckiesh is a valuable source for those who desire to have explained in clear, understandable terms the physics of light. Particularly well written is the introduction, which takes up the spectrum, the units (Angström, millimicron, micron) of measurement, the table of wave length of various spectral regions, and the discussion of the chronological research leading up to Millikan's remarkable success in spanning the gap to the roentgen rays. The chapter on solar radiation, combined with the later ones on transparency of solids and glasses, will be of particular interest to those engaged in rickets research. The author presents a chapter on the effects on living matter, which is mostly an abstract of the literature, replete with references; while this chapter is not a critical essay, the author, on the whole, shows conservatism.

ANAESTHETICS AND THEIR ADMINISTRATION. A Text-Book by the Late Sir Frederic W. Hewitt, M.V.O., M.A., M.D. Fifth edition, edited by Henry Robinson, M.A., M.D., B.Ch., Senior Anaesthetist to the Cancer Hospital, London. Cloth. Price, $9. Pp. 575, with 83 illustrations. New York: Oxford University Press, 1922.

This edition is a vast improvement over the fourth. Dr. Robinson, who has made radical revisions, was the editor for the previous edition under the direct auspices of Hewitt. The book virtually constitutes a thesis on anesthesia; it is up to date and abounds with references. Even the use of ethylene years ago is mentioned in the book, which is interesting in view of the recent work of Luckhardt and Carter in rediscovering the anesthetic properties. Dr. Robinson is not impressed by the propaganda that the value of ether is enhanced when made pure, and then charged with certain ketones, a small amount of ethylene and carbon dioxid. Concerning the proprietary form of this mixture, "ethanesal," the author says: "I have been unable to discover any advantage possessed by this anesthetic over ether; and in particular I believe that so far from being less liable (as is claimed) to cause vomiting, ethanesal is actually more often followed by vomiting than ether itself. Ethanesal is considerably the more expensive of the two." The evolution of surgical anesthesia is discussed, also the selection of anesthetics, and the extraneous circumstances of anesthetization, and there are chapters on the various drugs for general or local anesthesia. Prof. A. J. Clark collaborates on the physiology and mode of action of anesthetics, while the recorder of Smethwick presents a chapter on the medicolegal aspects. The book is excellently gotten up.

ORAL ROENTGENOLOGY. A Roentgen Study of the Anatomy and Pathology of the Oral Cavity. By Kurt H. Thoma, D.M.D., Assistant Professor of Oral Histology and Pathology and Member of the Research Committee, Harvard University Dental School. Second edition. Cloth. Price, $6. Pp. 341, with 470 illustrations. Philadelphia: Lea & Febiger, 1922.

As compared with the first edition, this has been considerably revised and enlarged, as to both text and illustrations. The first part is devoted to roentgen-ray technic, particularly for oral work, and contains many valuable suggestions not only for the operator, but also for others who interpret the films. The remainder of the book is an atlas rather than a textbook, the illustrations and their descriptions occupying about three fourths of the space. The second part is devoted to interpretation, attention being called to conditions that frequently lead to misinterpretations. The third part is a study of the normal tissues, and includes several excellent illustrations showing the development of the bicuspid and molar teeth and their relation to the temporary teeth. Similar illustrations of the incisor region would add to the value of this chapter. The fourth part is devoted to pathologic conditions, and includes excellent illustrations of abnormal dentition, odontomas, chronic mouth infections, cysts, fractures, and diseases of the facial sinuses. The fifth part is entitled "The Use of Roentgenograms as an Aid in Treatment," and the sixth part is devoted to oral examinations. In many instances, photographic reproductions of dissected specimens are shown alongside the roentgenographic illustrations, aiding materially in the better understanding of conditions. The book serves to impress the important place occupied by roentgenology in the practice of the dentist and the oral surgeon, and the value of roentgenographic studies of the mouth as a part of a thorough physical examination.

KURZGEFASSTE CHIRURGISCHE OPERATIONSLEHRE (Operationskurs). Für Studierende und Aerzte. Von Dr. Ad. Oberst, A. O. Professor a. d. Universität Freiburg I. Br., und Dr. H. F. O. Haberland, Privatdozent u. Assistent D. Chirurg. Klinik (Augusta-Hospital) der Universität Köln a. Rh. Second edition. Paper. Pp. 228, with 254 illustrations. Berlin: S. Karger, 1922.

This is a thorough revision of the work originally published by Oberst. As he no longer conducts a course in operative surgery, he has had Dr. Haberland join him as a co-author. Many antiquated operations have been omitted and newer operations added. Some of the illustrations have been improved and new ones added. Professor Frangenheim has reviewed the text and is credited with valuable suggestions. The work is divided into nine chapters. The first discusses incisions, methods of suturing and control of hemorrhage. The second considers the ligation of blood vessels. The third deals with amputations and disarticulations. The fourth deals with resection of joints, including operations on bones and tendons. The other chapters deal with operations on the head and face, on the neck, and on the chest, spine and hernias, and with abdominal and genitourinary operations. Each chapter is preceded by a page of illustrations showing the various instruments used. The work is fairly well illustrated, but the illustrations are hardly up to the standard. The descriptions of the operations are very brief; and there is nothing about the book that is unusual. It hardly equals the book by Schmieden, which has about the same scope, and cannot be compared with the excellent work by Axhausen, in which the operations are described in much greater detail, and made very clear by unusually excellent colored plates. For this reason it is not obvious why such a volume should be produced in Germany at this time.

APPLIED PHARMACOLOGY. By A. J. Clark, M.C., B.A., M.D., Professor of Pharmacology in the University of London. Cloth. Price, $4. Pp. 390, with 47 illustrations. Philadelphia: P. Blakiston's Son & Co., 1923.

The principal aim of Professor Clark is to bridge the gap between pharmacology and therapeutics, and to demonstrate as clearly as possible the connection between the two subjects. The book is addressed to the medical men of England; consequently, the terminology is not such as would appear in a textbook in this country, where the influence of the Council on Pharmacy and Chemistry exists. Proprietary names, of necessity, are frequent, and references to critical investigations such as made by the A. M. A. Council are often lacking. On the other hand, it is easily discerned that none realize the condition of British therapeutics more than Professor Clark, who is doing admirable work in the field of therapeutics, as expressed by his recent contributions on the unscientific "colloidal" preparations (such as the "collosols"), vitamin preparations and the like. In this book is reflected his discriminating attitude toward enthusiastic claims. The discussions are rather brief, but are to the point. At the end of each chapter is a list of the preparations containing the drugs under discussion, and a bibliography. The book is not replete, like Sollmann's or Cushing's pharmacologies, but to one desiring a compact book which is written from the therapeutic point of view, it is recommended.

Medicolegal

Physician Notifying Parents of Daughter's Infection

(Kenney et al. v. Gurley (Ala.), 95 So. R. 34)

The Supreme Court of Alabama reverses a judgment for $5,000 damages for alleged libel obtained by plaintiff Gurley against the physician who was the medical director, and the woman who was the dean of women of an educational institution. The plaintiff, having a swelling in the groin, had voluntarily gone to the hospital maintained on the school premises. She was examined by the medical director, and specimens from her were subjected to approved laboratory tests. From the examinations made, her trouble was diagnosed as gonorrhea. After treatment in the hospital for eighteen days, the dean sent her to her mother. Two or three days later the dean received a letter from the plaintiff inquiring whether, if she got well, it would be all right for her to return to school. A week later the medical director wrote a letter, addressed to the parents of the plaintiff, which he stated was done at the request of the dean, advising them that the plaintiff had been kept in the hospital ward as a result of venereal infection and because of the fact had been sent home; that, if it had not already been done, it was advisable that she be put under a good physician. This letter the medical director sent to the dean, who enclosed it in a letter which she wrote to the girl's mother, stating that it would be impossible for her daughter to return to the school; that the enclosed letter from the school's physician explained itself—it seemed to indicate that the girl had not been living right. Expressions from these letters were made the bases of this action.

The court says that the subject of this action belonged to the category of matter qualifiedly or conditionally privileged; and that pleas of conditional privilege are required to negative the presence of malice in the exercise of conditional privilege asserted in bar of a recovery, particularly if the complaint avers that the matter declared on was maliciously published. But, while it is essential that such a plea should negative malice in the exercise of conditional privilege characterizing the utterance declared on, yet the burden of proof to show actual or express malice in a privileged utterance is on the plaintiff, actual or express malice being requisite to render actionable matter that is or is found to be conditionally privileged.

On the dean of women and the medical director, within the sphere of their proper functions, there rested the duty to promote, to protect and to preserve the moral, sanitary and health conditions related to the institution; duties that comprehended affirmative obligations to the student body, to teachers and to the reputation of the institution. The authority to exclude from association with the school any who may be or become undesirable from either physical malady or moral obloquy is not debatable. The process and act of communication between the medical director and the dean of women with respect to the condition of the plaintiff while under their care and supervision, and subsequently when the return of the girl to the institution was under consideration, as well as the act of communicating to the parent alone the institution's reason for refusing to permit the girl's return, were privileged occasions.

A careful consideration of the whole evidence required the conclusion that the motion for a new trial should have been granted on the ground that neither the evidence nor any inference from evidence justified a finding by the jury that the requisite actual or express malice characterized the conditionally privileged utterances recited in the complaint. The expression that the circumstances seemed to indicate that the plaintiff had not been living right did not transcend the multiform obligations resting on the dean and the medical director in discharging their duties in the premises.

The application of requisite professional skill and care to the diagnosis of the plaintiff's condition at the time she was under the immediate medical supervision of the director and his assistants was fully established in the evidence. Even if the diagnosis then made, after the professional care and skill shown to have been then availed of was erroneous, or subsequently proved to be a mistake, that error of judgment, unimpeached in respect of its bona fides, would not serve to afford evidence of actual or express malice.

Employer's Liability for Fees Dependent on Notice

(Vesta Gas Range Mfg. Co. v. Payne (Tenn.), 246 S. W. R. 115)

The Supreme Court of Tennessee says that in this suit under the workmen's compensation act of that state the plaintiff employee, who had been injured and recovered a judgment against his employer, was awarded a physician's fee and statutory compensation from the date of the accident. He gave written notice of his injury about twenty days after the accident, which the defendant contended was not as soon as was reasonable or practicable. The law governing that feature of the case provides that, immediately on the occurrence of any injury, or as soon thereafter as is reasonable or practicable, every injured employee or his representative shall give or cause to be given to the employer written notice of the injury, and the employee shall not be entitled to physician's fees or to any compensation that may have accrued under the provisions of this act from the date of the accident to the giving of such notice, unless it can be shown that the employer had actual knowledge of the accident; and no compensation shall be payable under the provisions of the act unless such written notice is given the employer within thirty days after the occurrence of the accident, unless reasonable excuse for failure to give such notice is made. In this case, the trial judge should not have allowed a physician's fee, nor should he have allowed compensation to begin to run except from the date on which the notice was given, and the judgment recovered is modified accordingly.

Society Proceedings

COMING MEETINGS

Montana, Medical Association of, Butte, July 11-12. Dr. E. G. Balsam, 222 Hart-Albin Bldg., Billings, Secretary.

Oregon State Medical Association, Portland, July 10-11. Dr. C. L. Booth, Selling Bldg., Portland, Acting Secretary.

AMERICAN GYNECOLOGICAL SOCIETY

Forty-Eighth Annual Meeting, Held at Hot Springs, Va., May 21-23, 1923

The President, DR. JOHN A. SAMPSON, Albany, N. Y., in the Chair

Placenta Accreta: Its Incidence, Pathology and Management

DRS. JOHN OSBORN POLAK and GEORGE W. PHELAN, Brooklyn: The incidence of placenta accreta is about 1 in 6,000 cases. There is considerable confusion in the mind of the profession between simple adhesion of the placenta and true accreta. Accreta is a definite pathologic entity. Manual removal is impossible and can only result in hemorrhage, sepsis or perforation. Every delayed placenta with no hemorrhage should be viewed with suspicion; and no attempts at Credé's method should be made if the clinical signs of separation are not present. In the presence of an attached placenta without bleeding, aseptic exploration under anesthesia should be made to determine the subsequent procedure. If no line of cleavage can be demonstrated, hysterectomy should be done.

Pyelitis of Pregnancy

DR. NORRIS W. VAUX, Philadelphia: Pyelitis is a common complication of pregnancy. There is as yet no one specific cause on which to place the blame. The onset is mild and insidious, usually beginning after the bladder is drawn up out of its normal nonpregnant position from the third month onward. Bacilluria and frequent urination usually precede the systemic manifestation of pathologic change in the kidney substance. The renal infection is primarily hematogenous. Obstruction along the lower urinary tract in most cases is an essential factor in promoting infection of the kidney and its pelvis. The infecting organism is most com-

monly the colon bacillus. This may be the primary offender or a secondary invader on an infection by other pyogenic organisms. Because of the high germicidal qualities in the maternal blood, the blood stream culture is invariably negative. The prognosis is excellent for the continuation of pregnancy with conservative measures. In only the exceptional cases is it necessary to terminate pregnancy.

Chronic Leukorrhea

DR. ARTHUR H. CURTIS, Chicago: There is now general acceptance of my view that chronic infection of the body of the uterus is unusual; employment of the curet in attempts to relieve suspected endometritis is considered misdirected and harmful. In contrast, the cervix is believed to be an important focus of infection and a chief source of chronic leukorrheal discharges. Available measures in the control of chronic leukorrhea consist in eradication of gland infection in the vicinity of the urethra, dilation of cervical strictures, and destruction of hyperplastic or infected glandular tissues of the cervix. Cure of the diseased cervix may be achieved through radium application, which produces atrophy of the infected glands, or through surgical removal of the endocervix. Destruction of infected Skene's ducts and urethral glands, together with thorough dilation and radium treatment of the cervix, has been followed by recovery from chronic leukorrhea in 87 per cent. of 104 patients.

The Trend of Modern Obstetrics: What Is the Danger? How Can It Be Changed?

DR. BROOKE M. ANSPACH, Philadelphia: Routine induction, routine version and the routine prophylactic use of forceps increase the danger of childbirth to both mother and child. There is an unavoidable fetal mortality in labor of between 1.5 and 2 per cent. In other words, that proportion of infants at term will be born dead, irrespective of the methods employed. In reporting a series, the details of every fetal death should be given. The fetal mortality in conservative obstetrics may be estimated at about 1 per cent. at present. The woman in labor should have constant and continuous attendance of a competent obstetrician, throughout labor, no matter when it starts or how long it lasts. Labor should not be started or ended in a routine manner. Induction forceps and version should not be employed unless they are definitely indicated in the individual case for the sake of either the mother or the child. The practice of obstretrics should be carried on by obstetric partnerships; when this practice comes into vogue, objectionable routine methods will be abandoned, and maternal and fetal mortality statistics will improve.

Cystocele and High Rectocele

DR. THOMAS J. WATKINS, Chicago: Cystocele and high rectocele are hernias. Both are transverse lesions of the fascia at the upper part of the vagina. Both result from longitudinal tension on the fascia during labor, which produces a transverse rent. The transverse tear in cystocele permits the urethra to sag, and thus causes ureterocele and incontinence of urine. The transverse tear in high rectocele results in sagging of the perineum. The treatment of both should consist in a thorough dissection of the hernial sac and in firm repair along the line of the rent, namely, transversely. In cystocele this will result in restoration of the bladder and urethra to their normal positions. When these lesions are thoroughly dissected along the lines of the standardized method of repair of hernias, the operation is relatively simple and the result is almost certain of cure.

A Simple Method of Testing the Patency of the Fallopian Tubes

DR. N. SPROAT HEANEY, Chicago: As soon as Rubin described his method, and he and others had shown the harmlessness of the transufflation, I adapted the use of the ear syringe to testing the patency of the tubes from below. Not only has this been tried on every case of sterility examined since that time, but experience has been gained by trying transsufflation in every case in which the peritoneal cavity was to be opened either vaginally or abdominally. All patients are tested in the lithotomy position. With the usual preliminary precautions, the cervix is exposed by narrow vaginal retractors and is grasped with bullet forceps. In the usual case, the cervix can be drawn down far enough so that the plain, one-ounce, all rubber ear syringe can be adapted to the cervical canal. Frequently the cervix will not come down this far without discomfort, in which event a syringe is used which has had a straight or curved medicine dropper glass inserted into the rubber nozzle. In rare cases the cervical canal is so patulous that a glass connecting tube is used instead of the medicine dropper. In most cases air readily passes into the peritoneal cavity with a peculiar audible whistling or gurgling sound. Occasionally, light pressure must be used before the air passes. If the tubes are closed, air refuses to pass after the syringe is about half empty. If the syringe empties, there is assurance that the tubes are open. When doubt occurs as to regurgitation at the external os, the vagina may be filled with water until the cervix is immersed, or a lubricant may be used in the cervical canal, so that if leakage occurs, bubbles will be seen. At Barton Cooke Hirst's suggestion, a stethoscope is placed on the abdomen just above the pubes, and auscultation shows whether the air passes through only one or both tubes.

In the first few tests, I was not prepared for the ease with which the air passed through the tubes, so that several syringefuls were used, with the resultant shoulder pains which are typical of a quantity of gas in the peritoneal cavity. With added experience, one syringeful of air makes a conclusive test, so that patients are spared the shoulder pains and experience no discomfort except the transitory bite of the bullet forceps. The method is simple of performance and conclusive in its findings. No training is necessary to perfect the technic. Any one capable of performing a curettage is able safely and definitely to make conclusive record regarding the patency of the fallopian tubes.

Follow-Up Results in 908 Cases of Uterine Cancer Treated by Radium

DRS. HAROLD C. BAILEY and WILLIAM P. HEALY, New York: The advanced primary cancer forms the largest group of our patients. If we take the first three years, 1915, 1916 and 1917, in which the irradiation was without any decided amount of cross-firing, there were in all eighty cases, and but two women are alive. In 1918 with the use of the bomb and block, there were forty-one cases, and six women, or 14.5 per cent., are alive and free from the disease today. In 1919 there were sixty-nine cases with but five, or 7 per cent., well, and two alive with the disease progressing. In 1920 there were ninety-two cases, with eight, or 8.7 per cent., alive and no evidence of cancer, and seven alive with symptoms. In 1921, there were eighty-five cases, and twelve, or 14 per cent., have no evidence, and nineteen are in various stages of the disease. In 1922 there were eighty cases, and twelve patients, or 15 per cent., are apparently well, and forty-five others are alive. While not enough time has elapsed since the treatment of the cases of the last two years to give any idea of the final results, still of the 165 cases that were beyond the aid of surgery, twenty-four cases now show no clinical signs of cancer.

In the early operable group there were eleven cases treated previous to Jan. 1, 1919. Of these, three patients, or 27 per cent., are alive and free from evidence of cancer for five years or more. If the rate is corrected by deducting three deaths from intercurrent disease and one following operation in another clinic, the result is 43 per cent. clinically cured for the period. In the last four years there were forty-eight cases, and of these, thirty-two, or 66 per cent., are free from evidence of the disease. If we are permitted to deduct three cases, in one of which the patient died after an operation in another hospital a week after our treatment, and two others giving false addresses so that they could not be followed, there are thirty-two alive of forty-five patients, or 71 per cent. In these early cases we naturally look for and hope to get excellent results from irradiation, and very few of our cases receive any other treatment.

Previous to 1918, there were fifty-two cases. Two of these patients are alive and well, and one other is alive, but with some evidence of tumor. In the last five years, during which time the technic has been considerably elaborated by the use of cross-firing and the embedding of radium emanation in the lesion, a remarkable number of these cases has been apparently cured. There were 168 cases in this group, and thirty-eight, or 22 per cent., show no clinical evidence of cancer. We have had forty-one cases of cancer of the body of the uterus, of which twenty-one patients, or 49 per cent., are alive and well. Three of these have passed the five year period. Nine of the twenty-one patients had hysterectomy following the irradiation. In the other cases, hysterectomy was not considered advisable because of the other complications or constitutional diseases, and these cases have been treated by irradiation alone.

Relation Between Placenta and the Secretion of Milk

DR. OSKAR FRANKL, Vienna, Austria: That the fetus is not the deciding factor in the secretion of milk is proved by active lactation subsequent to the expulsion of a hydatidiform mole or a dead fetus. Ovarian function in relation to lactation is distinguished by the fact, on the one hand, that castration performed during pregnancy does not preclude lactation, while, on the other hand, in the experience of animal breeders, castration is successfully resorted to for the purpose of prolonging lactation in the mother animal. Halban first asserted that it is directly the loss of the placenta that changes the secretion of colostrum into one of milk. To prove or disprove this theory I carried out certain experiments which consisted in the transplantation of the placenta of a mouse under the skin on the back of another mouse. Such grafts in general led to three possible end-results. In case of an intervening infection, a large abscess formed, destroying the implanted placenta. In other cases, under aseptic conditions, the graft did not take and the placenta became rapidly necrotic. In the third successful group, the implanted placenta established satisfactory connection with the adjoining tissues, and the organ could be observed to persist for three or four weeks. After this time, histologic study showed a complete absorption of the grafted placenta.

In these experiments the placentas of pregnant mice were employed within ten or twelve days of full term, and transplanted under the skin of the back of mice approximately in the same stage of pregnancy. In this group of successful transplants, mice from a strain known to be able to nurse satisfactorily their young, would have litters of five or six. The new-born offsprings would seem normal in their appearance and would immediately begin to nurse the mother animal; but they invariably died within the next five to seven days, evidently from starvation. Investigations showed that the mamma of the mother animal was secreting colostrum and not milk. In the unsuccessful transplants of the first and second groups, lactation proceeded normally. The successful transplantation of a placenta on a pregnant animal causes persistence of colostrum secretion. Clinical experience points to the fact that the placenta must be regarded as an organ endowed with endocrine activity, whose function it is during pregnancy to prepare the breast glands for the secretion of milk, and simultaneously to prevent secretory activity.

The Teaching of Obstetrics and Gynecology

DR. W. B. HENDRY, Toronto: Existing conditions at the University of Toronto made it possible, eleven years ago, to combine the departments of obstetrics and gynecology under one head, and since that time an organization has been evolved through which the training has been carried on much more efficiently than in former years. The responsibility of the dual department rests with the head, and with him are associated two senior and several junior assistants and demonstrators. The service is a rotating one, by which a one-sided development of the staff is avoided. The junior assistants alternate every three months in obstetrics and gynecology, while continuity of the service is maintained by having one member of the staff permanently responsible to the head for the proper administration of each of the subdivisions: outpatient and inpatient services in obstetrics; outpatient and inpatient services in gynecology, and the pathologic laboratory, which is maintained distinct from the department of general pathology. The staff, as a whole, is on a part-time basis, but two demonstrators and one resident are on a full-time basis and are engaged in research work as well as assisting with the teaching. The resident fellow obtains his appointment as such after having served satisfactorily for one year as intern on a rotating service in a general hospital, one year as senior intern in obstetrics and gynecology, and one year in general pathology and bacteriology. He may later be taken on the staff as a full-time demonstrator, and in due course be appointed to the visiting staff of the hospital and of the medical faculty.

Hydro-Ureter and Hydronephrosis: A Frequent Secondary Finding as a Result of Prolapse of the Uterus and Bladder

DRS. JOSEPH BRETTAUER and I. C. RUBIN, New York: Although the number of cases herein reported (eight) is small, the large percentage of hydronephrosis and hydroureters encountered in them must have an important bearing on the etiologic relationship between the two. When taken together with the large incidence (fifteen out of twenty-three necropsies) so carefully studied by Tandler and Halban, there can be no question as to the secondary effects produced on the kidneys by long-standing prolapses. It becomes at once clear that the need for early operations to correct descensus and genital prolapse must be recognized. That at least pessaries should be worn in inoperable cases if not for the relief of the prolapse itself, but also to save the kidneys from secondary damage, must also be recognized. In advanced, neglected cases it becomes all the more important to take measures to study and conserve kidney function before undertaking operative correction of the prolapse. Greater attention to phenolsulphonephthalein and indigocarmin output, to analysis of the blood for nitrogen retention, etc., may indicate the extent of kidney damage entailed by these women with genital prolapse. The simple testing of the capacity of the renal pelvis and ureter by the use of sterile water alone will be sufficient to determine the degree of ureteral dilatation. The injection of sodium iodid or of sodium bromid in solution will be reserved for doubtful cases, and one ureter will be adequate for the demonstration.

The Relation of the Endometrium to Ovarian Function

DRS. CHARLES C. NORRIS and M. E. VOGT, Philadelphia: The theory that the endometrium possesses an endocrine function is, at present, based only on physiologic and clinical proof. The fact that the endometrium differs histologically from other endocrine glands is no argument against the theory, since all other endocrine glands differ one from the other in this respect. The endometrium probably possesses a definite endocrine function, which, like other endocrine glands, acts in conjunction with certain so-called ductless glands, particularly the ovary, to which it is most likely subservient. The endocrine function of the endometrium probably fluctuates with the menstrual cycle, being most active during the premenstrual period. The chief clinical evidence on which this theory is based lies in the established fact that the proportion of women who suffer from nervous phenomena subsequent to hysterectomy with conservation of one or both ovaries is much greater than that of those who exhibit painful or palpable changes in the conserved ovary. The most conclusive evidence is found in those patients who have been treated with radium for the arrest of benign hemorrhages. It is difficult to conceive that in almost every case so treated both ovaries are rendered functionless. Furthermore, there is much experimental evidence that tends to show that in these cases the action of radium is limited to the uterus. In operations on the uterus, ovarian conservation is of distinct value, even if panhysterectomy is performed; the ovaries function better, however, and have a longer functional life, if a portion of the endometrium can be preserved. The thickened and permanent premenstrual stage of the endometrium, so frequently present in cases of

uterine myoma, is the result of stimulation of the endometrium by the presence of the tumor, and accounts for the prolonged bleeding that is often present.

A Case of Periumbilical Ecchymosis Associated with Acute Salpingitis

DR. EDWARD A. SCHUMANN, Philadelphia: A review of the case reported leads to the emphasis of three points: Periumbilical ecchymosis can occur without the existence of ectopic gestation, and in the absence of any free blood within the peritoneal cavity. The association of an extremely acute and fulminating salpingitis, so acute that, on operation, eight hours after the onset there were no adhesions whatever, observed about the tubes, in the presence of a normal intrauterine pregnancy, is most unusual and points to an infection by way of the blood and lymph channels. The smooth postoperative course after salpingectomy for acute salpingitis suggests the possibility that the universally practiced conservatism regarding operative procedure in the acute stages of this lesion may be exaggerated.

Some Observations on Placental Infarcts

DR. FRED L. ADAIR, Minneapolis: White infarcts do not all fit into the same category, and probably result from a number of different processes. The most of these localized degenerative processes which are grouped under the name of placental infarct might all lead to the formation of white infarcts if a sufficient length of time elapsed between the time of their occurrence and the delivery of the placenta. A number of causes operate to produce these localized areas of degeneration in the placenta, among which may be mentioned vascular changes, such as endarteritis, periarteritis and thrombosis, localized hemorrhages which may result from stasis, traumatic or toxic conditions. Disturbance of the afferent blood supply may be responsible for trophic disturbances resulting in degeneration of the areas supplied by these vessels. Infection and inflammatory processes may play a rôle in the causation of some of these degenerations.

Abdominal Hysterotomy Under Morphin, Scopolamin and Local Anesthesia

DR. FREDERICK C. IRVING, Boston: Abdominal hysterotomy offers a method of emptying the uterus easily and rapidly in those cases in which such a procedure is demanded. Local anesthesia under morphin and scopolamin narcosis is superior to general anesthesia because any possible danger from an inhalation anesthetic is eliminated, and operative shock is reduced to a minimum. This method is therefore applicable to patients classed as bad surgical risks. Among such patients are those having heart disease with previous decompensation; nephritis; diabetes, and pulmonary tuberculosis, or those who have acute respiratory infections on whom it is necessary for other reasons to perform cesarean section.

Blood Pressure Changes Following Delivery

DR. OTTO H. SCHWARZ, St. Louis: Marked drops in blood pressure following delivery in cases of toxemia have not been sufficiently emphasized. The drops that occur in these cases frequently amount to 100 mm. of mercury, and if the patient is not promptly stimulated, the condition may lead to shock. Importance should be placed on the immediate application of a tight abdominal binder, with sand bags to the abdomen, stimulation of the patient as in the treatment of shock, the use of pituitary extract, and the avoidance of too long a delay in the use of intravenous therapy in the form of glucose solutions or blood transfusion. These marked drops were noted in ten cases, but this is by no means an index to their frequency. It is a noteworthy fact that forced operative delivery and anesthesia are prominent features in several of the cases reported, but cannot be held totally responsible for the occurrence of the condition. In normal cases, operative procedure, the anesthetic, sudden emptying of the uterus and the physiologic bleeding do not produce marked drops in pressure, or cause the patient to go into shock; but in the toxemia cases, perhaps chiefly owing to the presence of toxic substances, the factors mentioned act in an accumulative way to produce the condition.

MEDICAL SOCIETY OF THE STATE OF NEW YORK

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(Concluded from page 1954)

Surgical Treatment of Gastric and Duodenal Ulcer

DR. GRANT C. MADILL, Ogdensburg, N. Y.: I do not advocate excision because my experience does not lead to the current teaching that chronic ulcer of the stomach becomes malignant. So many conditions simulate chronic ulcer that its diagnosis, even by most expert roentgenologists and diagnosticians, is very difficult. The fictitious finding of ulcer and the performance of gastrojejunostomy in neurotic subjects whose gastric symptoms are but part of a general neurosis has probably led to more failures in surgery of the stomach than any other cause.

DISCUSSION

DR. WALTER A. BASTEDO, New York: In acute perforations there can be no doubt as to the need of immediate surgery. The continuous or repeated hemorrhagic ulcers certainly are potential dangers, and need operation. The hour-glass stomach needs operation. The really obstructed pylorus is also a case for operation; but the showing of a six-hour retention by roentgen ray does not exclude the possibility that it can be treated by medical means. I think that all statistics tend to show that it is not probable that many ulcers change to cancer, but rather that there are a great many ulcers which are cancer to begin with. I know of scarcely a surgeon in New York who has had a case in which resected tissue from the stomach was found to be cancer by the pathologic laboratory who could report that patient living five years after the operation. Nevertheless, when a resection can be done, surely we should advocate it; for even if the lesion should prove to be cancerous, we still have hope, if not of cure, at least of postponement of the serious outcome.

DR. ARTHUR L. HOLLAND, New York: Dr. Bastedo just stated that ulcers are sometimes cancers without our knowing it. I think Dr. Pool has had a number of such instances in which he operated for ulcer and later found cancer cells in the floor of the ulcer.

DR. JOHN F. CONNORS, New York: For years and years we have spent a great deal of time devising new operations for the cure of gastric and duodenal ulcer. If some of this energy were used in attempting to find the etiology of gastric and duodenal ulcer, we would be much better off. It is my belief that gastro-enterostomy is of little or no value in the treatment of gastric ulcer, particularly when the pylorus is patent.

DR. EUGENE H. POOL, New York: Initial gastro-enterostomy in perforated gastric and duodenal ulcers can be done in early cases, within six hours, without adding materially to the risk of the operation. The objection is that one adds an unnecessary and often a disadvantageous element in treatment. There is a 2 to 3 per cent. risk of a marginal ulcer developing after any gastro-enterostomy; moreover, in about 20 or 25 per cent. of gastro-enterostomies functional disturbances occur. A secondary gastro-enterostomy can be done relatively safely and needs only be done where it is necessary.

String Test for the Diagnosis of Ulcer of the Stomach

DR. MARSHALL CLINTON, Buffalo: Roentgen-ray diagnoses have enough margin of error so that the routine examination of patients by the string test is of unquestionable value. Like other laboratory tests, its chief value lies in a proper translation.

DISCUSSION

DR. ARTHUR L. HOLLAND, New York: As the fluoroscopic method of examination, which is cheaper than the plate method, came in, I gradually abandoned the string test. The objection to it was that very frequently the string did not get past the duodenum. If we were deprived of the roentgen ray, I would use the string test. I think it would be a very

good thing to check up and differentiate between an active and an old healed ulcer. That cannot always be done by roentgen ray.

Dr. Max Einhorn, New York: It is very important that the string test be done in the right way. If it is not, we have all kinds of trouble. I have made comparative tests with the roentgen ray and with the string test. Most of these patients are not operated on; they do well without any operative procedure. I resort to surgery when it is necessary, and I usually find that the results of the string test tally more often with the operative results than do the roentgen-ray findings. The diagnosis of duodenal ulcer is often very difficult, and the intricate signs of ulcer can be caused by some other lesions. The string test is most accurate in these conditions.

Chronic Partial Obstruction of the Duodenum

Dr. Alfred S. Taylor, New York: In the present series of cases, disturbances occurred at or near the junction of the first and second portions of the duodenum in eighty-one cases, and at or near the duodenojejunal angle in twenty cases. In two instances, the duodenum was constricted behind the transverse mesocolon. In the first group, disturbance has always been caused by atypical peritoneal membranes, termed "hepatoduodenal membranes," otherwise known as "Harris bands." They cause high fixation, angulation or compression of the duodenum, or all three combined. In the second group, disturbances occur from two causes: (1) atypical peritoneal folds or ligaments causing angulation or compression, or both combined, at the duodenojejunal angle, and (2) compression of terminal duodenum by the superior mesenteric vessels. Clinical symptomatology is strongly suggestive of disease of the biliary tract, ulcer of the stomach or duodenum, etc. In these somewhat indefinite cases, the conditions causing chronic partial obstruction should always be kept in mind, and the proper evidence for either making or excluding the diagnosis should be sought. Such evidence lies in a history of digestive disturbances over a long period, symptoms intermittently increasing in severity and duration with corresponding increase in disability. Most of the patients have been labeled as neurasthenics. Physical examination shows a variable state of nutrition; the blood is negative, except for slight anemia; results of gastric analysis and stools are not characteristic. Abdominal exploration may show distension of the cecum and ascending colon with tenderness over the cecum, the middle of the ascending colon and hepatic flexure; the stomach may be dilated, and reach well to the right of the median line. Usually, there is a tender spot in the midepigastrium just to the right of the midline. Roentgen-ray findings, properly interpreted, and fluoroscopy furnish the most definite evidence for or against the diagnosis. The treatment should primarily be medical for a considerable length of time, and only those cases who do not improve in spite of prolonged medical treatment should be referred to the surgeon. The results in these cases, from eight and a half years down to four months after operation, are: forty-three cures; thirty-eight greatly improved; nine improved; seven failures; two deaths and four lost track of.

DISCUSSION

Dr. Charles J. Hunt, New York: The first thing that is necessary is roentgen-ray confirmation, and the second is surgical intervention. The importance of the phenomena symptomatically increases in proportion from above down. That is, the Harris bands have caused less violent disturbances than when the transverse colon is involved.

Dr. Walter L. Niles, New York: I regard this condition as very important. A very large group of patients who are regarded as being neurasthenic have a disturbance of function of the duodenum as the basis for their nervous instability. The gastric symptoms are very often overshadowed by neurasthenia. Headaches are common, and some have attacks of migraine; insomnia and palpitation are usual. The gastric symptoms consist chiefly of distention and fulness after meals, and belching of gas. When you see a neurasthenic individual whose chief gastric complaint is belching, be very suspicious of duodenal deformity. Severe attacks of pain are occasionally seen, but most of the patients complain only of painful distress in the epigastrium. Vomiting is not frequent, but most patients vomit occasionally, especially when under nervous or mental strain. There are no characteristic findings in the gastric contents or stools. The diagnosis is based almost wholly on the roentgen ray. Combined use of the fluoroscope and plates is most satisfactory. Only a small proportion of these cases demand surgical intervention, medical treatment being quite satisfactory in the majority of cases. The indications for operation cannot be clearly defined, as every patient must be considered individually. They should certainly be given the chance of probable benefit from medical treatment. Generally speaking, the older the patient, the longer he has had his symptoms, and the less successful will be the result of operation, yet some of the long-standing cases recover surprisingly well, but it naturally takes many months for satisfactory restoration of a function which has been disturbed for many years.

Dr. Harry M. Imboden, New York: The accurary of roentgen-ray examination depends more or less on the type of stomach. If it is the common fish-hook type of stomach, the relative position of the duodenum may be easily determined. If, on the contrary, one is confronted with the so-called "steer-horn" type of stomach, it is not quite such a simple procedure.

Dr. Jacob Sarnoff, Brooklyn: I want to bring out a point in regard to the superior mesenteric vessels as a factor in causing obstruction. In demonstrating to the students on the cadaver the viscera, we filled all the organs with air. The most difficult organ to demonstrate was the duodenum until we used that method which I termed pneumoviscera. By inserting air we found the duodenum stands out very clearly retroperitoneally, and it showed how the superior mesenteric vessels obstruct the flow of the air. Clinically, these particular vessels might also do the same thing in causing obstruction.

Dr. Alfred S. Taylor, New York: As a surgeon, I am definitely in favor of these patients having long medical care, and allowing the medical man to treat them until he is ready to quit.

Ankylosis: Its Importance and Treatment by Arthroplastic Measures

Dr. W. R. MacAusland, Boston: In general, only the following joints are to be considered for arthroplasty in the order of frequency: the elbow, hip, knee, temporomaxillary (jaw), wrist and fingers. Other joints should be excluded from the list because the ankylosed joint in good position will give good function. The contraindications to arthroplasty are: The tuberculous joint, which rarely, if ever, lends itself properly to operative interference. No stiff joint should be mobilized which causes slight disability. No joint should be mobilized when contraindicated by the patients' age or general condition. The ultimate success in these cases depends very largely on the after-treatment.

DISCUSSION

Dr. Percy W. Roberts, New York: One thing which I think is important is the time of operation after an infectious arthritis. There should be a long delay, but his experience on the point should be of some value to us.

Dr. Joseph A. Blake, New York: I noticed, in some of the operations at the Reconstruction Hospital, that they have been suspending the arms of patients after operation on the elbow. The elbow is kept fixed for six or seven days, and then simply suspended to an overhead by adhesive straps and allowed to swing a little. Then the patient is instructed to move the joint himself while suspended, and the results have been excellent. In the war Leriche did remarkable operations on the joints, the elbow particularly.

Dr. W. R. MacAusland, Boston: Operations should never be done until at least two years after all signs of active infection have subsided. A sensitive joint should be left alone. The method we use, whether suspension or the various overhead traction methods, does not matter very much. I am using them all.

Present Status of Irradiation in the Treatment of Carcinoma of the Breast

DR. BURTON J. LEE, New York: For the purposes of classification, I divide mammary carcinoma into seven groups: papillary cystadenocarcinoma; adenocarcinoma; so-called Paget's disease, fibrocarcinoma, carcinoma simplex, cellular carcinoma and inflammatory carcinoma. The results in surgery may not depend so much on the technic as on the type of carcinoma and the degree of operability at the time of surgical intervention. It is obvious that these different types of carcinoma will not require the same treatment. In case of papillary cystadenocarcinoma, where the tumor is not large, a properly done excision should be sufficient. This is the only type of mammary carcinoma in which preoperative and postoperative irradiation should be unnecessary. In adenocarcinoma, if the axillary nodes are not involved, a conservative operation is advised. If they are involved, a radical amputation should be performed. Preoperative roentgen-ray treatment should be given. If Paget's disease is seen early, a reasonably local operation may be done; if later, operation will have to be radical, with the same roentgen-ray treatment. With fibrocarcinoma and carcinoma simplex, a Willy Meyer-Halsted operation and the same line of treatment are used. Inflammatory carcinoma should not be operated on. These cases have done well with properly planned roentgen-ray dosage. The vast majority of recurrences are of the inoperable type, and should be treated by irradiation. The deep treatment with the new high voltage machine is rarely used for such cases. The only instance in which it is employed are for recurrences in the spine and pelvis or some deep, inaccessible area. In primary inoperable cases, the high voltage machine has been used on large breasts. As a rule, superficial roentgen-ray treatment is given, and radium is applied to the primary tumor by means of the so-called platinum needles, which give better results that the bare tubes.

The Limitations of Radiotherapy of Cancer

DR. FRANCIS CARTER WOOD, New York: The limitations of radiotherapy in the treatment of cancer are (1) physical; (2) peculiarities in the roentgen-ray susceptibilities of the patients; (3) difficulties based on the relation of the tumor to the important organs of the body; (4) those based on the peculiarities of the tumors themselves. Regarding the physical limitations, for example, it is impossible to treat a tumor three or four inches from the surface of the body with a roentgen-ray machine giving no higher voltages than those used for photographic purposes. For such deep therapy, high voltage machines must be used in order to give sufficient penetration. As an illustration of the second limitation, there are patients who are so sensitive to both radium and roentgen ray that even light treatments produce serious symptoms, and satisfactory therapeusis is impossible. The third limitation is best illustrated by the difficulties in the treatment of cancer of the stomach. Any attempt to give large doses of roentgen ray to this organ compromises the suprarenals, pancreas and the liver, and renders all satisfactory radiotherapy in this region difficult if not impossible. Concerning the fourth limitation, human tumors vary very greatly in their susceptibility to irradiation, and as yet not enough is known concerning the relations between the type of tumor and its susceptibility to enable a definite conclusion to be drawn as to whether a tumor will yield to irradiation or not.

DISCUSSION ON RADIOTHERAPY

DR. MILTON G. WASCH, Brooklyn, N. Y.: When it comes to the question of radiotherapy, there is a lack of uniformity in technic and in the interpretation of dosage which has been so common that we often do not understand each other. Up to the present, the best results from radiotherapy have been produced by the burying of the radium needle in the tumor mass. That is the most rapid way of controlling tumor growth. It is limited to local lesions. We get the best results in malignant disease of the cervix and uterus because the lesion is local, and with a carcinoma of the cervix uteri we can bury the needles and surround the carcinoma mass with radium. With the roentgen ray we shall get better results as we develop a perfect and uniform technic.

DR. ISAAK LEVIN, New York: The insertion of radium into the tumor is undoubtedly today the most efficient as well as the most economical method in the whole field of radiotherapy. In my opinion, the use of bare capillary tubes of radium emanation is by far superior to the insertion of metal needles containing the radium salts or radium emanations. As for roentgen-ray therapy, the higher the voltages used, the better the results, but, as Dr. Wood stated, the greater the voltage, the greater is the danger to the patient. The general effect of the high voltage roentgen-ray therapy on the organism apparently differs in different individuals.

DR. JAMES E. SADLIER, Poughkeepsie, N. Y.: Some time ago I made a study of cases of carcinoma of the breast which had received irradiation treatment; 49.6 per cent. were free from recurrence.

DR. FRANCIS CARTER WOOD, New York: I do not advise preoperative irradiation, because I feel that time is lost. A carcinoma is a dangerous thing, and as soon as a diagnosis is made, the operation should be done within twenty-four hours, if possible. A patient should not be allowed to carry a mass of cells which at any moment may metastasize into the mediastinum, when the whole question becomes purely academic, as nothing can then save the patient. Knowing that such an occurrence may take place at any moment, I do not feel like keeping a patient for two or three weeks for preoperative irradiation, because we know the amount of roentgen ray which penetrates into the tumor is not sufficient to kill all the cells. If we could kill all the cells of a tumor by such irradiation, we would not have to resort to surgery. I believe postoperative radiation will be done more and more, and ultimately will be used not only in the breast, but in other regions.

DR. A. JOSEPHINE SHERMAN, New York: How early do pathologists find the cancer cells in the blood and lymphatics?

DR. FRANCIS CARTER WOOD: Unfortunately we find them in the lymphatics rather early. In the fatal cases, they are found in the lungs very frequently, where they have been transported by the blood and deposited in the pulmonary vessels.

Certain Criteria of Management in Prostatic Carcinoma

DR. ERNEST M. WATSON, Buffalo: In dealing with prostatic carcinoma, the relief of symptoms, frequency of urination, pain, dysuria and possibly retention, and the control of the cancer with its debilitating effect are important factors. In very early and moderately well developed carcinoma, which gives few symptoms, and shows only limited obstructive signs, bare seeds of radium emanation are implanted into the substance of the prostate gland through the perineum. In this type of case the outlook is most hopeful. In early and moderately well developed carcinoma, giving marked subjective symptoms, with little or no evidence of any generalized debility and no demonstrable metastases, large doses of radium pack in several areas are given to diminish the viability of the cancer cells previous to operation. Prostatectomy is carried out through the perineum. At the conclusion of the removal of the obstructing tissue the posterior capsule or commissure, the region of the lateral lobes, anterior commissure, and periprostatic tissue are planted with the bare seeds of radium emanation, each containing about 0.6 to 1 millicurie each. The wound is closed in layers. In three months, further external radiation by the high power roentgen ray or the radium pack is given. In cases previously subjected to operation presenting obstructive symptoms due to a cicatricial or a thin carcinomatous ringlike contracture at the vesical orifice, associated with the obstruction, the procedure is first a punch operation as devised by Young. Radium seeds are planted in the substance of the posterior lobe through the perineum. Radium packs or high power roentgen rays are given over the groins, suprapubic region, sacrum and perineum. In cases with marked obstructive symptoms, due to a recurrence of the prostatic growth, treatment is palliative. The procedure of choice is suprapubic cystotomy with a permanent drainage tube. Seeding through the perineum, external packs, and high power roentgen rays supplement operation. In markedly advanced cases, nothing can be done but a varying degree of palliation.

Current Medical Literature

AMERICAN

Titles marked with an asterisk (*) are abstracted below.

American Journal of Ophthalmology, Chicago

6: 353-448 (May) 1923

Iridotasis Operation for Glaucoma. M. Goldenburg, Chicago.—p. 353.
Acute Glaucoma Following Heine's Cyclodialysis. Y. Yoshida, Kyoto, Japan.—p. 356.
Mechanism and Use of Variable Five Minute Test Letter. J. M. Thorington, Philadelphia.—p. 361.
Review of Keratoplastic Surgery and Some Experiments in Keratoplasty. A. E. Forster, Kalamazoo, Mich.—p. 366.
Experimental Study of Pathogenesis of Quinin Amblyopia with Special Reference to Ethylhydrocuprein Hydrochlorid. A. E. Forster, Kalamazoo, Mich.—p. 376.
Ophthalmia Neonatorum. L. Lehrfeld, Philadelphia.—p. 380.
Eye in Beri-Beri. A. S. Fernando, Manila, P. I.—p. 385.
Clinical Aspects of Eye Symptoms in Lethargic Encephalitis. W. G. Cameron, Tacoma, Wash.—p. 389.
Functional Chromo Periodic Hemianopsia. J. N. Rhoads, Philadelphia.—p. 392.
Fugacious Homonymous Hemianopsia. J. M. Banister, Omaha.—p. 396.
Thrombosis of Central Retinal Vein. H. Wood, Nashville.—p. 400.
Associated Movements of Upper Lid and Jaw. C. J. Adams, Kokomo, Ind.—p. 401.
Rebounding Intraocular Foreign Body. W. S. Reese, Philadelphia.—p. 401.
Hiccup Followed by Loss of Vision. J. H. Gross, St. Louis.—p. 402.
Butyn as Local Anesthetic in Minor Surgical Ocular Operations. E. L. Vernon, Chicago.—p. 402.

California State Journal of Medicine, San Francisco

21: 193-236 (May) 1923

Pyelography: Common Diagnostic Errors. M. B. Wesson, San Francisco.—p. 193.
Congenital Elevation of Scapulae. A. L. Fisher, San Francisco.—p. 203.
*Insulin Treatment of Diabetes Mellitus. A. H. Rowe, Oakland.—p. 204.
Medical Social Service in Hospital. M. A. Wales, San Francisco.—p. 209.
Cerebral Syphilis. N. H. Brush, Santa Barbara, Calif.—p. 212.
Psychoneurosis as Problem for General Practitioner. C. P. Kjaerbye.—p. 214.
Applicability of Alkalinization in Treatment of Tuberculosis. F. P. Miller.—p. 216.
Experiments on Bactericidal Action of Violet Ray. E. B. Fisher, Pacific Grove, Calif.—p. 218.

Insulin Treatment of Diabetes Mellitus.—Rowe has treated twenty-five diabetic patients with insulin, with very gratifying results. He says that for those patients who will be steadfast to their diets and who will take insulin in proper doses, the outlook for health and freedom from diabetic complications is practically assured. Patients in coma, providing the circulation does not fail, can usually be restored to consciousness and gradually be brough back to strength and well-being by the use of insulin. However, delay in the recognition of severe acidosis and semicoma is serious. The importance of careful laboratory control by urinary and blood plasma analyses when insulin is to be used is insisted on. To assure accuracy, these tests must be done by experienced chemists who have a large amount of such work continually at hand. The various alveolar air, blood, and urine tests for acidosis must be available in the treatment of severe diabetes. The carbon dioxid tension in blood plasma is especially important. Moreover, glycosuria due to renal diabetes must be recognized, and such patients with normal blood sugars ought not receive insulin. Four cases of diabetes in children, from the ages of 2 to 8 years, are being well controlled by insulin and dietary therapy.

Journal of Biological Chemistry, Baltimore

55: 567-864 (April) 1923

Nucleotids Formed by Action of Boiled Pancreas on Yeast Nucleic Acid. W. Jones and M. E. Perkins, Baltimore.—p. 557.
Formation of Nucleotids from Yeast Nucleic Acid by Action of Sodium Hydroxid at Room Temperature. W. Jones and M. E. Perkins, Baltimore.—p. 567.
New Optical Instrument for Determination of Hemoglobin. H. S. Newcomer, Philadelphia.—p. 569.
Influence of Radiant Energy on Development of Xerophthalmia in Rats: Demonstration of Beneficial Influence of Sunlight and Out of Door Air on Organism. G. F. Powers and E. A. Park, New Haven, Conn.—p. 575.
*Investigations on Immediate Effect of Heavy Exercise (Stair Running) on Some Phases of Circulation and Respiration in Normal Persons. III. Effect of Varying Amount and Kind of Exercise. C. Lundsgaard and E. Möller, Copenhagen, Denmark.—p. 599.
*Effect of Some Organic Acids on Uric Acid Excretion of Man. H. V. Gibson and E. A. Doisy, St. Louis.—p. 605.
Composition of Corn Pollen. II. Concerning Certain Lipoids, a Hydrocarbon, and Phytosterol Occurring in Pollen of White Flint Corn. R. J. Anderson, Geneva, N. Y.—p. 611.
*Rate of Urea Excretion: VII. Effect of Various Other Factors Than Blood Urea Concentration on Rate of Urea Excretion. T. Addis and D. R. Drury, San Francisco.—p. 629.
Rate of Urea Excretion: VIII. Effect of Changes in Urine Volume on Rate of Urea Excretion. T. Addis and D. R. Drury, San Francisco.—p. 639.
Studies on Enzyme Action: XXII. Lipolytic Actions of Various Tissue and Tumor Extracts at Different Hydrogen Ion Concentrations. H. M. Noyes, K. Sugiura and K. G. Falk, New York.—p. 653.
Some Derivatives of Cystin and Cystein. G. J. Shiple and C. P. Sherwin, New York.—p. 671.
*Studies of Carbon Dioxid Absorption Curve of Human Blood: I. Apparent Variations of pK_1 in Henderson-Hasselbalch Equation. J. P. Peters, H. A. Bulger and A. J. Eisenman, New Haven, Conn.—p. 687.
Studies of Carbon Dioxid Absorption Curve of Human Blood: II. Nature of Curve Representing Relation of p_H to $BHCO_3$. J. P. Peters, A. J. Eisenman and H. A. Bulger, New Haven, Conn.—p. 709.
*Utilization of Carbohydrate by Rats Deprived of Vitamin B. H. A. Mattill, Rochester, N. Y.—p. 717.
Inorganic Salt Metabolism: II. Inorganic Ion Ration After Administration of Oxalates and Citrates. E. G. Gross, New Haven, Conn.—p. 729.
Possible Factor Influencing Assimilation of Calcium. C. H. Hunt, A. R. Winter and R. C. Miller, Wooster, Ohio.—p. 739.
Lysolecithins and Lysocephalins. P. A. Levene and I. P. Rolf, New York.—p. 743.
Method for Determination of Dissolved Carbon Dioxid. F. G. Hall, Madison, Wis.—p. 751.
*Mechanism of Phlorhizin Diabetes. T. P. Nash, Jr., and S. R. Benedict, New York.—p. 757.
Sugar Elimination After Subcutaneous Injection of Glucose in Dog. S. R. Benedict and E. Osterberg, New York.—p. 769.
Possible Asymmetry of Aliphatic Diazo Compounds. IV. P. A. Levene and L. A. Mikeska, New York.—p. 795.
Calculation of Iso-electric Points. P. A. Levene and H. S. Simms, New York.—p. 801.
Bios Requirement of Bakers' Yeast. J. J. Willaman and A. G. Olsen, St. Paul, Minn.—p. 815.

New Instrument for Determination of Hemoglobin.—The principle on which Newcomer's instrument is constructed is the making of a photometric match between a standard filter of 1 mm. section of yellow glass on one side, and a sample of blood diluted with 1 per cent. hydrochloric acid on the other. The readings are said to be very accurate.

Effects of Stair-Running.—The effect (a marked decrease in the oxygen content of venous blood drawn from the arm) of fast stair-running noted by Lundsgaard and Möller was just as marked if the subject ran up and down one flight of stairs once as it was after stair-running five times. No change in the oxygen content of the venous blood drawn from the arm was observed (*a*) after the subject had walked slowly up and down one flight of stairs, (*b*) after riding a bicycle (with brakes on) for from 2 to 2½ minutes, and (*c*) after exercise with the arm (lifting a heavy load).

Effect of Lactic and Pyruvic Acids on Uric Acid Excretion.—Gibson and Doisy found that the ingestion of sodium salts of lactic acid causes a decrease, and ingestion of pyruvic acid an increase in the excretion of uric acid.

Variability of Urea Excretion.—Addis and Drury state that the rate of urea excretion is increased by the administration by mouth of milk, caffein, and glutamic acid, and is decreased by exercise, pituitary extract and large amounts of epinephrin. These alterations in the rate occur independently of changes in blood urea concentration.

Studies of Carbon Dioxid Absorption Curve of Human Blood.—The data presented by Peters et al., support the contention of Warburg that $pK1$ of the Henderson-Hasselbalch equation shows an apparent variation with hemoglobin concentration and with p_H. Warburg's correction factors have, however, proved unsatisfactory when applied to the data of these experiments. A quantitative estimation of the variations of $pK1$ has been made and a series of curves has been presented by means of which corrections can be made. By means of these curves the p_H of plasma can be predicted from carbon dioxid content and carbon dioxid tension of whole blood with a mean error of less than $\pm$ 0.01 p_H.

Vitamin B and Carbohydrate Metabolism.—From data presented by Mattill on the respiratory quotients of rats on rations with and without vitamin B it appears that this

substance is not related specifically to the metabolism of carbohydrate since after feeding cane sugar or glucose the quotients rose in both cases, slightly less rapidly in the vitamin deprived group due probably to delayed absorption. Basal quotients were alike in both groups; nonfasting quotients were slightly lower in the vitamin deprived animals, thus reflecting their semifasting condition. A simple apparatus is described by which, in conjunction with a Haldane apparatus for gas analysis, respiratory quotients can be determined on small animals in from twenty to forty minutes.

Mechanism of Phlorizin Diabetes.—Dextrose ingested in sufficient amount to induce protracted hyperglycemia in phlorizinized dogs is recovered quantitatively in the urine. The view is suggested by Nash and Benedict, that phlorizin not only affects the permeability of the kidney tissue to blood sugar, but produces an intrinsic impairment of the sugar burning mechanism. When a mixture of dextrose and urea is ingested by a phlorizinized dog, the sugar is excreted in the urine more rapidly than the urea. The phenomenon is similar to that observed when meat or proteins are fed to phlorizinized dogs, and discredits the interpretation of a more rapid production of sugar than urea in amino-acid metabolism.

Military Surgeon, Washington, D. C.

52: 455-566 (May) 1923

Dysentery: Laboratory Diagnosis, Epidemiology and Treatment. J. E. Ash.—p. 455.
Intestinal Parasites of Small Group of Siamese Soldiers. W. H. Beach and H. R. O'Brien, Bangkok, Siam.—p. 510.
Spinal or Mental? Use and Abuse of Manipulation. T. A. Williams, Washington, D. C.—p. 514.
Post Swimming Pool. J. C. Magee.—p. 524.
Medical Examination of Recruits. H. V. Wurdemann.—p. 536.
Clogging of Sewer Pipes by Gordiacea. A. L. Parsons.—p. 541.
Case of Acute Suppurative Meningitis. A. T. Cooper, Ft. Benning, Ga.—p. 543.
Annual Death Rates. M. W. Hall.—p. 545.

Nebraska State Medical Journal, Norfolk

8: 153-184 (May) 1923

Medical Practitioner and American Society for Control of Cancer. J. E. Rush.—p. 153.
Clinical Interpretation of Systolic Murmur. William N. Anderson, Omaha.—p. 156.
Common Clinical Arrhythmias. W. Thompson, Omaha.—p. 160.
Degenerative Heart or Myocardium as Prime Factor in Cardiac Disease. G. W. Covey, Lincoln.—p. 163.
Common Problems in Eye Diseases of Infancy and Childhood. S. R. Gifford, Omaha.—p. 165.
Treatment of Acute Sinusitis. G. B. Potter, Omaha.—p. 168.
Acute Gastritis. M. L. Wilson, Falls City.—p. 170.
Postgraduate Work in Diseases of Children in England and on Continent. F. S. Clarke, Omaha.—p. 172.
Ten Cases of Pulmonary Tuberculosis. M. J. Breuer, Lincoln.—p. 174.
*Case of Exceptionally Rapid Recovery Following Removal of Spinal Cord Tumor. J. J. Keegan, Omaha.—p. 176.

Rapid Recovery After Removal of Spinal Cord Tumor.—Keegan relates the case of a patient who was completely paralyzed below the level of the second dorsal cord segment and two weeks after the operation walked from the hospital with practically no evidence of motor impairment. The case also is noteworthy from the fact that it was complicated by pregnancy of four months' duration which was not interrupted by the operation. The spines and laminae of the sixth and seventh cervical and the first thoracic vertebrae were removed, exposing the dura. A firm nodule could be felt beneath the dura. The dura was incised, exposing a small oval firm white tumor on the left dorsolateral surface of the cord. The tumor was not adherent to the dura, but deeply indented the nervous tissue, appearing embedded in its substance. It was easily removed by gentle traction on the overlying membranes and dissection without disturbing the cord. The tumor was an endothelioma.

New Jersey Medical Society Journal, Orange

20: 145-180 (May) 1923

Vicissitudes of Doctor's Life. J. M. T. Finney, Baltimore.—p. 145.
Effect of Pregnancy on Tuberculosis. B. S. Pollak, Hoboken, N. J.—p. 154.
Renal Infections in Pregnancy. S. R. Woodruff, New York.—p. 158.
Evaluation of Symptoms and Signs in Diagnosis of Pulmonary Tuberculosis. A. E. Jaffin, Jersey City, N. J.—p. 162.
Climate in Treatment of Tuberculosis. M. I. Marshak, Bayonne, N. J.—p. 164.

New Orleans Medical and Surgical Journal

75: 695-748 (May) 1923

*Resection of Rectum with Restoration of Anal Outlet. C. W. Allen.—p. 695.
*Fractures of Scapula. E. Bloch, New Orleans.—p. 704.
*New Method of Treating Fractures of Neck of Femur. E. D. Martin and A. C. King, New Orleans.—p. 710.
Chronic Urinary Disturbance in Women. A. Nelken, New Orleans.—p. 716.
Pylorospasm. F. J. Kinberger, New Orleans.—p. 722.
Charity Hospital of Louisiana. A. E. Fossier.—p. 728.

Resection of Rectum with Restoration of Anus.—After establishing a temporary colostomy, Allen frees the involved bowel from above and below—by laparotomy and by perineal dissection—so that the rectum can be pulled down, bringing with it the tumor and healthy bowel above. The tumor is resected and an end to end anastomosis is made. From ten days to two weeks later the colostomy opening is closed. This operation permits of complete restoration of anal function and perfect bowel control.

Fracture of Scapula.—Among 8,097 fractures reviewed by Bloch there were twenty-eight fractures of the scapula. All were caused by direct violence.

Fractures of Neck of Femur.—What Martin and King propose to do is to fix the head of the femur so securely to the trochanter that it will move freely with the shaft, leaving the joint free. When union has taken place and the patient is allowed to walk, in each case the joint was movable and locomotion was begun with ease and comfort. This is done by driving two No. 8, three inch, wood screws through the trochanter and into the neck and head of the femur and screwing them tight enough to pull the fractured surfaces into close and firm apposition and to hold them together until union is firm, that means for at least three months. The operation can be done with local anesthesia.

New York Medical Journal and Medical Record

117: 585-648 (May 16) 1923

Beginnings of Diagnosis. J. Wright, Pleasantville, N. Y.—p. 585.
Pluralism in Medicine and Therapeutics. H. A. Bosma, Groningen, Holland.—p. 589.
*Treatment of Severe Diabetes with Insulin. N. B. Foster, New York.—p. 591.
Antipituitary Serum. C. Legiardi-Laura, New York.—p. 594.
Mental Concomitants of Diabetes Mellitus. C. B. Masson, Washington, D. C.—p. 598.
Surgery in Diabetic Patients. H. Cohen, New York.—p. 606.
Nutritive Value of Pasteurized and Condensed Milk. P. B. Hawk, C. A. Smith and R. A. Lichtenthaeler, Philadelphia.—p. 609.
Some Points in Examination of Heart for Life Insurance. F. W. Price, London.—p. 613.
Mitral Stenosis. J. Barr, London.—p. 619.
Case of Actinomycosis of Lungs Simulating Tuberculosis. H. Besser, New York.—p. 623.
Message to Laity. J. W. Kennedy, Philadelphia.—p. 624.

Insulin in Treatment of Diabetes.—Foster reports two cases in which insulin was used with good result. One patient represents the type who, under ordinary circumstances, would not be able to carry on any occupation, but who, with the aid of insulin, pursues light occupations and makes his living. The second case was one of diabetic coma in which the patient recovered. Another field in which insulin has proved of great help is in the treatment of diabetes with surgical complications. Several cases of this kind that Foster has had the opportunity to treat with insulin resulted so satisfactorily that he thinks it is safe to say that could one start with insulin before operation one could be reasonably sure that the patient would not die of diabetes.

New York State Journal of Medicine

23: 137-182 (April) 1923

Common Vaginal Discharges Encountered in Practice. J. E. King, Buffalo.—p. 137.
Fundus Oculi in Toxemias of Pregnancy. J. L. Behan, Brooklyn.—p. 140.
*Postmortem Findings in the New-Born. H. C. McDowell, Buffalo.—p. 143.
*Bleeding and Coagulation in First Week of Life. D. H. Sherman and H. R. Lohnes, Buffalo.—p. 146.

Types of Pneumococci Found in Pneumonia of Infants and Young Children. M. Wollstein, New York.—p. 148.
Hereditary Glaucoma Simplex (Juvenile Glaucoma). A. C. Snell, Rochester, N. Y.—p. 151.
Acute Anaphylactic Reaction Following Intravenous Injection of Arsphenamin. B. P. Thom, New York.—p. 155.
Treatment of Deafness and Tinnitus. H. Hays, New York.—p. 157.
Problem of Hospital Costs and Training School Problem from Viewpoint of Surgeon. E. MacD. Stanton, Schenectady, N. Y.—p. 160.
Recent Progress in Communicable Diseases of Childhood. C. Herrman, New York.—p. 165.

Postmortem Findings in the New-Born.—Among 3,000 deliveries reported by McDowell, the fetal mortality was 4.6 per cent. There was a total of 183 fetal deaths of which 49.2 per cent. were stillborn. The probable causes of deaths were: Birth trauma, 38; prolapsed cord, 4; placenta praevia, 7; toxemia, 18; fetal abnormalities, 2; craniotomies, 3. Hemorrhagic conditions in most instances were the result of cord complication accompanied with asphyxia neonatorum and placental complications. Syphilis rarely caused death of the fetus. By the elimination of forceps delivery, McDowell asserts, the number of birth injuries is reduced. All were cases of delivery by version.

Bleeding and Coagulation Time in First Week of Life.—In twelve of 100 cases reported by Sherman and Lohnes, the clotting time was prolonged to from ten to sixteen minutes, and in twenty-eight cases the bleeding time was prolonged to from six to 25 minutes. There was only one case of cerebral hemorrhage. This infant had a bleeding time, on the second day, of ten minutes, and a clotting time of fifteen minutes. It was given 10 c.c. of whole blood subcutaneously, and the next day the bleeding time was three minutes, and the clotting time six minutes. It made a complete recovery. From this work certain facts present themselves. It has been demonstrated that there is a definite blood dyscrasia in the new-born, characterized by interference with the normal clotting of the blood. This condition is not due to immature development, since it is not usually present at birth, but develops on the second or third day. It is not more frequent in the prematurely born infant than in the full term infant. This condition of hemophilia is temporary. It subsides before the tenth day. It is fairly frequent, being present in 28 per cent. of these 100 cases. It is characterized by prolonged bleeding time rather than by prolonged clotting time. The great clinical importance of this subject lies in its connection with cerebral hemorrhage. In an infant with a tendency to bleed, a slight trauma may be serious, even fatal.

Northwest Medicine, Seattle

22: 153-188 (May) 1923

Our Surgical Heritage Through Life Work of Dr. John McLoughlin. J. B. McNerthney, Tacoma.—p. 153.
Trifacial Neuralgia. Treatment. A. W. Adson, Rochester, Minn.—p. 156.
Acute Epidemic Encephalitis. K. Winslow, Seattle.—p. 160.
Pathology of Lethargic Encephalitis. O. J. West, Seattle.—p. 163.
Cerebral Symptoms of Lethargic Encephalitis. G. W. Swift, Seattle.—p. 166.
Lowering Morbidity and Mortality Rate of Toxic Goiter. J. E. Else, Portland.—p. 167.
Chronic Running Ear. O. M. Rott, Spokane.—p. 170.
Case of Cerebral Abscess Following Acute Mastoiditis. Operation. Recovery. C. W. Pond, Pocatello, Idaho.—p. 172.
Practical Points in Diagnosis of Cardiac Disorders. G. H. Anderson, Spokane.—p. 174.

Oklahoma State Medical Association Journal, Muskogee

16: 83-108 (April) 1923

Primary Acidosis as Seen in Infants. N. J. Dieffenbach, Tulsa.—p. 83.
Neurosyphilis, Its Diagnosis and Treatment. M. Q. Howard, Oklahoma City.—p. 84.
Four Years a Medical Missionary in China. J. W. Brown, Tulsa.—p. 88.
Surgery of Seminal Vesicles. E. G. Mark, Kansas City, Mo.—p. 92.

Philippine Journal of Science, Manila

22: 345-465 (April) 1923

New Hymenoptera from Malayan Region. S. A. Rohwer.—p. 345.
Philippine Species of Genus Prothyma and Other Cicindelinae. W. Horn.—p. 357.
*Feeding Experiment on Two Hundred Lepers at Culion Leper Colony, Philippine Islands. H. Embrey.—p. 365.
Interesting New Water Strider from Formosa. Teiso Esaki.—p. 387.
Chinese White Wax Scale, Ericerus Pela Chavannes. I. Kuwana.—p. 393.
Method of Illustrating Insect Wings. C. S. Banks.—p. 407.
Histopathology of Intestine in Cholera. E. W. Goodpasture.—p. 413.
*Complement Fixation in Treated and Untreated Leprosy. E. W. Goodpasture.—p. 425.
*Poisonous Constituent in Cholera Stools. E. W. Goodpasture.—p. 439.
Alexander Schadenberg. His Life and Work in Philippines. O. Scheerer.—p. 447.
Certain Developmental Stages of Ascaris Lumbricoides Ova in Liver Tissue. C. Monserrat and C. Africa.—p. 459.

Dietotherapy of Leprosy.—Embrey employed a high calory diet, an adequate supply of fresh vegetables and fruits, and to supplement the insufficient fish ration with a cheap available protein, he used mungo, *Phaseolus aureus* Roxburgh, a bean which is abundant in the islands. Previous analysis and experimental feeding with this bean showed that it contains about 22 per cent. of protein, which is of fairly good quality. The daily basal ration for an adult leper consisted of unpolished rice, 400 gm.; mungo, 300 gm.; salted pork or fat, 20 gm.; fresh native vegetables, from 300 to 400 gm. The total food value of this diet was: protein, 98 gm.; fat, 23.6 gm., and carbohydrate, 517.4 gm. The caloric value was approximately, 2,807. Children from 8 to 12 years of age were given seven-tenths of the amounts prescribed, and in addition one glass of milk a day. Three hundred grams of fish or meat could be substituted for the mungo, but with such substitution the rice ration or the vegetable ration was increased from 400 to 500 gm. This increase was recommended because neither fish nor lean meat has the caloric value of the mungo bean. Of the 200 persons included, 164, or 82 per cent., gained from 100 gm. to 5.1 kg. in weight. Only 14.5 per cent. of the patients decreased in weight, with an average decrease of 1.3 kg. per person; 3.5 per cent. remained stationary. The increase was more frequent in patients under 50 years and was almost negligible in patients over 50 years of age. Lepers in the incipient stage of the disease are more prone to variations. Of the fifty-four patients composing the incipient group, 90.7 per cent. increased in weight, and none remained stationary. Of the 101 patients forming the middle group, 83.1 per cent. gained in weight, and 11.8 per cent. lost weight. Of the forty-five advanced cases, 68.8 per cent. gained weight, and 26.6 per cent. lost weight. Embrey believes that the conclusion seems justified, that a high calory diet, with an adequate supply of mineral matter, of vitamins and of that substance found in green vegetables which aids in the deposition of calcium is beneficial to lepers and that their weight and general health are improved thereby.

Complement Fixation in Leprosy.—The Wassermann reaction was found to be positive by Goodpasture in 60 per cent. of untreated nodular and mixed cases of leprosy and in 84 per cent. of similar cases treated with chaulmoogra oil or its products for a few months but still bacteriologically positive. In sixteen cases of nodular and mixed leprosy that had become clinically and bacteriologically negative under treatment with chaulmoogra oil, the Wassermann reaction was uniformly negative. One hundred per cent. positive complement fixation tests were obtained in twenty-four cases of nodular, mixed and anesthetic lepers, using an antigen composed of a suspension of *Bacillus tuberculosis* (human). In twenty cases of nodular and mixed leprosy, clinically and bacteriologically negative after treatment with chaulmoogra oil or its products, two were negative, three gave complete fixation, one was strongly positive, and fourteen weakly positive, with a suspension of *B. tuberculosis* as antigen.

Poisonous Constituent in Cholera Stools.—The sudden and often violent onset of cholera with early collapse, fall in blood pressure, low body temperature, and loss of fluid through the intestine, Goodpasture says, are sufficiently unique to suggest the possibility of a fundamental element in the pathogenesis of cholera which is lacking in other infectious diseases. Indeed, these symptoms have a greater similarity to those of high intestinal obstruction than to any other enteric infection. It has been possible, by precipitating filtered watery stools and intestinal fluid from cases of cholera with alcohol, to demonstrate the presence of a poisonous substance producing, when injected intravenously or intra-

peritoneally into dogs, a train of symptoms and pathologic changes identical with those caused experimentally by poison from closed duodenal loops.

Porto Rico Medical Association Bulletin, San Juan

17: 1-75 (March) 1923

*Sprue in Tropical Regions. B. K. Ashford.—p. 1.
*Leprosy and Its Treatment. P. N. Ortiz.—p. 27.
*Bubonic Plague in 1921. R. Lavandero.—p. 40.
*Id. P. Morales Otero.—p. 49.
Diagnosis of Bubonic Plague. P. N. Ortiz.—p. 56.
*Examinations of Plague Sputum in Porto Rico. S. Giuliani.—p. 61.
Pasteur. S. Giuliani.—p. 63.
History of Use of Chaulmoogra Acid as Specific Remedy for Leprosy. R. del Valle Sárraga.—p. 65.

Sprue in the Tropics.—This is a Spanish translation of Ashford's monograph published in the *American Journal of the Medical Sciences*. It was reviewed in THE JOURNAL, April 7, 1923, page 1027. It is based on 1,470 cases of this moniliasis, and clinical studies since 1908.

Leprosy.—Ortiz relates that the new chaulmoogra oil esters supplied by the U. S. Public Health Service, have been available in Porto Rico for a year and a half, and forty lepers have been given this treatment to date. In seven cases it had to be abandoned on account of intolerance; nine patients have been notably improved, and eleven have shown slight improvement. In thirteen no effect was apparent. The benefit is most pronounced in the younger patients, and they bear intramuscular injections better than the elderly ones. He has been trying to perfect an intravenous method of giving the drug, as the patients shrink from intramuscular administration. Ten cases are illustrated, "before and after."

The 1921 Epidemic of Plague in Porto Rico.—Lavandero comments on the stormy onset and rapid violent course of the twenty-four cases of plague in his charge. There was suppuration in the buboes in six of the thirteen cases, with recovery. The serial urine findings aided in the prognosis: In some cases numerous tube casts and 0.8 per cent. albumin gradually disappeared as recovery progressed, while other patients, with almost normal urine findings, succumbed. The elimination of chlorids proved a reliable index of the gravity of the disease. The adults with less than 0.05 per cent. chlorids nearly all died. The insufficiency of the myocardium, manifested by retention of chlorids, is the most reliable element for the prognosis. In seven of the eleven fatal cases, the patients were not seen till after the third day of the disease, and two died in half an hour. The amount of antiserum required for a moderately severe case is more than is specified in the textbooks; from 250 to 500 gm. should be injected at six, eight or twelve hour intervals at first.

Plague in Rats at Porto Rico.—Morales Otero states that the 1921 epidemic of plague in Porto Rico had been preceded by the finding of numerous dead rats in the streets. More than 78,300 rats were examined. The plague bacillus was found in ninety-three. The rats came from ten different localities, but San Juan was the main focus.

Diagnosis of Plague.—Ortiz relates that thirty-three cases of plague were found among 600 persons examined in quarantine, and seven were held as suspects. The symptoms of acute parenchymatous nephritis were sometimes the earliest to attract attention. The diagnosis was confirmed by the intense prostration, high fever, extremely painful bubo (in or near the triangle of Scarpa in 85 per cent. of the cases; multiple in 12 per cent.) retention of chlorids and high polymorphonucleosis. No case of plague developed in a rat-proof house.

Examination of Plague Sputum.—Giuliani describes the "five slide" method in use at the Porto Rico biologic laboratory. A different staining method is applied to each of the five slides.

Southern Medical Journal, Birmingham

16: 327-406 (May) 1923

*Anatomic Study Contrasting Dementia Praecox Constitution with That of Paranoid Developments. N. D. C. Lewis, Washington, D. C.—p. 327.
*Lipodystrophia Progressiva. Report of Two Cases. T. P. Sprunt, Baltimore.—p. 333.
Cardiospasm, Associated with Aneurysm, Aortitis and Angina: Report of Twenty-Three Cases. J. R. Verbrycke, Jr., Washington, D. C.—p. 338.
Spasm at Cardia and Cardiospasm. J. Friedenwald and T. H. Morrison, Baltimore.—p. 341.
*Septic Meningitis in Five Year Old Child. W. A. Mulherin and V. P. Sydenstricker, Augusta, Ga.—p. 348.
Tonsils in Childhood. L. T. Royster, Norfolk, Va.—p. 351.
Limitations of Laboratory Examinations. J. R. Bean, Birmingham.—p. 358.
Thyroidectomy Under Local Anesthesia. C. W. Allen, New Orleans.—p. 364.
Enterostomy. E. Drennen, Birmingham.—p. 366.
*Pyelitis in Pregnancy. E. H. Kloman, Baltimore.—p. 369.
Use of Lane Bone Plate. A. W. Ralls, Gadsden, Ala.—p. 375.
Intestinal Rupture from External Trauma without Extra-Abdominal Evidence: Report of Two Cases. C. A. Vance, Lexington, Ky.—p. 380.
Prostatectomy. M. L. Boyd, Atlanta, Ga.—p. 385.
Some Disputed Points in Suprapubic Prostatectomy. G. R. Livermore, Memphis, Tenn.—p. 389.
Acute Otitis Media in Children. J. B. Greene, Ashville, N. C.—p. 395.

Anatomic Construction in Dementia Praecox.—One group of 601 cases of dementia praecox coming to necropsy was examined by Lewis as to the anatomic construction, and another smaller group composed of twenty-two unselected cases, representing all cases of this disorder examined postmortem during eight months, was also examined from this standpoint, and in addition the major endocrine glands were studied in detail. It was apparent that one of the chief differences from the anatomic viewpoint between this group and other mental disorders was in the circulatory and lymphatic systems, and evidence was obtained strongly indicating that this difference was a fundamental one: that is, that it was a part of the organization at birth, not acquired unless very early in life and not the product of, or influenced profoundly by, prolonged visceral disease. The average weight of the dementia praecox heart is one-third less than the normal or average, the small size being independent of race, age, sex, size of body, duration of psychosis, or lethal lesion. It stands out in considerable contrast with the other mental disease groups. Pronounced alterations in the suprarenal cortex were as constant a feature as regressive atrophy of the testes. In 50 per cent. of the cases there was a definite arrest in the cortical development. Accessory suprarenals were frequently found in the dementia praecox group. The thyroid gland has been found altered in its connective tissue and colloid structures in such a manner as to suggest a functional association with the genital glands.

Effective Treatment of Lipodystrophia Progressiva.—The chief point made by Sprunt is that the factors producing the atrophy do not necessarily remain completely effective, that fat can be deposited again in the parts from which it has disappeared. In his two cases the treatment consisted of: rest in bed, a full and varied diet, with extra nourishment after meals, general massage, three times a week, and small doses of sodium cacodylate administered hypodermically every day.

Septic Meningitis in Young Child.—The causative microorganism in the case reported by Mulherin and Sydenstricker resembled *Streptococcus viridans*. The primary focus of infection probably was the tonsils. The route of infection probably was through the lymphatics, and not hematogenous. There was excessively high fever (113 F.) when bronchopneumonia became superimposed. Localized encephalitis in the area of the red nucleus probably contributed to the height of the fever. The patient's blood agglutinated the offending organism in dilution of 1:40, showing acquired immunity.

Pyelitis in Pregnancy.—Kloman reports twenty-eight cases of pyelitis in pregnancy, seven of which required treatment other than medical, and ten of which have subsequently proved to be stricture cases. Four of the twenty-eight patients were examined for stricture and found to have normal ureters. The seven patients requiring treatment other than medical were treated by dilating the stricture and by pelvic lavage. The remaining twenty-one cases were treated medically; that is, forced water, hexamethylenamin and some alkaline diuretic, which sufficed to take them through pregnancy.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

Bristol Medico-Chirurgical Journal

40: 71-118 (March) 1923

Diagnosis of Peptic Ulcer and Its Bearings on Treatment. T. Carwardine.—p. 71.
Unsuccessful Tonsil and Adenoid Operations. A. J. M. Wright.—p. 84.
Light Ether Anesthesia. A. L. Flemming.—p. 88.
Intracranial Tumors and Occurrence of Papilledema. A. E. Iles.—p. 94.

Journal of Pathology and Bacteriology, Edinburgh

26: 137-304 (April) 1923

*Enquiry Into Genesis of Mammalian Blood Platelet. S. P. Bedson.—p. 145.
*Fungus Isolated from Guinea-Pigs Inoculated with Virus of Typhus Fever. J. Segal.—p. 156.
Passage of Staphylococcus Aureus Through Kidney of Rabbit. S. C. Dyke.—p. 164.
Immunity to Antiplatelet Serum. S. P. Bedson.—p. 176.
*Paramycetoma (?) of Forearm. W. E. De Korte.—p. 189.
*Wassermann Reaction in Scarlet Fever. E. M. Dunlop.—p. 193.
Relationship of Autolysin and Wassermann Antibody in Serum of Paroxysmal Hemoglobinuria. R. P. Smith.—p. 196.
*Size of Parathyroids of Rats, and Effect of Diet Deficiency of Calcium. E. M. Luce.—p. 200.
*Influence of Removal of Sexual Glands on Skeleton of Animals Kept on Normal or Rickets-Producing Diets. V. Korenchevsky.—p. 207.
Spontaneous Rickets in Rats. V. Korenchevsky.—p. 222.
Reaction to Bacilli Tuberculosis in Albino Rat. S. Gloyne and D. S. Page.—p. 224.
*Examination of Blood Gases and Respiration in Disease, with Reference to Cause of Breathlessness and Cyanosis. J. M. Campbell, G. H. Hunt and E. P. Poulton.—p. 234.
Mucoid Casts from Vermiform Appendix. L. Corbett and D. Keilin.—p. 297.
Rapid Histologic Sections, Gelatin Embedded and Fixed Throughout Preparing. Diathermy Excision of Diagnostic Pieces. Simple Modification of Twort Staining. Syrup Gelatin Mountant. Slide Index Box. R. Donald.—p. 299.
Relationship of Blood Platelet and Red Corpuscles: Attempt to Group Human Platelets with Red Cell Grouping Serums. T. Toda.—p. 303.
Rapid Method of Ripening Hematoxylin with Hypochlorite. J. Anderson.—p. 303.

Genesis of Blood Platelet.—Evidence is advanced by Bedson in support of the view that the platelet is the homologue of the thrombocyte of avian blood, the nucleus being lost, however, before the cell reaches maturity, and that it appears in the circulation in the nonnucleated form just as in the case of the red corpuscles.

Fungus Isolated from Guinea-Pigs Inoculated with Typhus.—A fungus belonging to the genus *Paecilomyces* has been isolated by Segal from guinea-pigs inoculated with the virus of typhus fever. This organism is pathogenic for guinea-pigs. The condition produced in the guinea-pig by the inoculation of this fungus resembles experimental typhus in this animal, in that it is a transmissible fever, accompanied by changes in the brain similar to certain stages of the typhus lesion.

Paramycetoma of Forearm.—The fungous element noted by de Korte in his case consisted of the nonseptate hyphae of a phycomycete of the family *Mucorineae*. The mycelium consisted of discrete "hyphae" which did not branch or anastomose. No minute grains were discovered, and the hyphal elements, from their arrangement, did not lend themselves to collection into microscopic grains. As the specimen was received in a preservative, no cultural experiments were undertaken.

Wassermann Reaction in Scarlet Fever.—The serum from seventy-seven cases of scarlet fever was tested by Dunlop and no evidence was obtained that scarlet fever, at any stage of the disease, is the cause of a positive Wassermann reaction.

Effect of Calcium Deficient Diet.—Luce noted that rats fed on a diet deficient in calcium show a consistent enlargement of the parathyroid gland. This enlargement is due to hyperplasia, not hypertrophy of cells. The hyperplasia has no definite relationship to weight or sex, but increases progressively with length of time of feeding on the calcium deficient diet. It is not accompanied by corresponding changes in the thyroid gland. On a vitamin A deficient diet a hyperplasia sometimes occurs in young rats.

Effect of Castration on Bone Growth.—Chemical and histologic examinations made by Korenchevsky failed to show any essential influence of castration on the skeleton of growing rats fed on a normal diet. Similarly, castration produces no perceptible change in the degree and character of rickets produced in growing rats by deficient diets.

Cause of Breathlessness and Cyanosis.—In the cases showing cyanosis and breathlessness and in control cases without breathlessness, Campbell, Hunt and Poulton have determined the value of carbon dioxid in the arterial blood, the carbon dioxid dissociation curve, the carbon dioxid fixing power (volume of combined carbon dioxid at 40 mm. carbon dioxid pressure), and the carbon dioxid in true plasma. Cases of mitral stenosis, anemia, polycythemia, congenital heart disease, primary functional deficiency of the lung in young subjects, mixed pulmonary and cardiorenal disease of elderly subjects were observed. Full reports of the findings are given. It is suggested that bronchial spasm is the most important cause of the sensation of breathlessness; rapidity of respiration is next in importance, while increase in the depth of respiration is of least moment.

Lancet, London

1: 939-988 (May 12) 1923

Ulcerative Colitis. H. Rolleston.—p. 939.
*Treatment of Liver Abscess by Aspiration. P. Manson-Bahr, G. C. Low, J. J. Pratt and A. L. Gregg.—p. 941.
*Treatment of Internal Derangements of Knee Joint: New Method of Operative Exposure. A. G. T. Fisher.—p. 945.
*Thrombosis of Mesenteric Artery. A. Cawadias and J. Catsaras.—p. 949.
Epidemic of "Fourth Disease." H. M. Raven.—p. 950.
*Operative Treatment of Malignant Disease: Special Reference to Tongue. H. J. Paterson.—p. 951.
*Case of Spontaneous Rupture of Heart. R. L. Ley.—p. 953.
*Case of Traumatic Rupture of Aorta. P. R. Kemp.—p. 953.

Treatment of Liver Abscess by Aspiration.—Fifteen cases are reported by Manson-Bahr et al. in which there have been no deaths nor even supervention of any untoward symptoms following aspiration, combined with medicinal treatment. An ordinary Potain's aspirator is used. The needle should not be inserted to a depth exceeding 3¾ inches. When pus is struck by exploratory puncture, complete evacuation of the abscess cavity should at once be carried out as part of the same operative procedure. Should the pus prove too thick for aspiration, Manson's trocar and cannula can be inserted along the tract of the aspiration needle, and a free evacuation of the abscess cavity thereby obtained. No definite instructions are laid down about the site of puncture; the site of election should be the point of greatest tenderness and swelling, should such exist. In the absence of any localizing signs, the routine procedure adopted by the authors has been: (1) eighth interspace in anterior or midaxillary line, (2) the epigastric route. Without a general anesthetic not more than three punctures at one time are advocated, but under general anesthesia success has attended the search for pus after as many as six punctures. As much pus as possible should be evacuated at one aspiration. No special advantage seems to accrue from the injection of emetin or other amebicidal substances into the abscess cavity. Healing appears to take place without them. The effusion of serum into the abscess cavity probably normally takes places and should be regarded as the natural method of repair. The risk of hemorrhage after multiple punctures, although theoretically great, in practice appears to be of small import. Whenever possible, puncture of lung tissue should be avoided as increasing the risk of hemorrhage.

Treatment of Internal Derangements of Knee Joint.—Adequate exposure of the joint is the object aimed at by Fisher. He makes a slightly curved incision which commences above in the midline, an inch above the uppermost limits of the suprapatellar pouch, skirts the inner border of the patella and the inner border of the ligamentum patellae, and ends below, slightly to the inner side of the tubercle of the tibia. The flap of skin and subcutaneous tissues is reflected outward to slightly beyond the outer border of the patella. The patella is dislocated to the outer side of the joint, and on further flexion of the joint an excellent exposure is obtained of the whole of the anterior compartment. The introduction

of the finger into the joint is unnecessary, since with suitable retraction every part is brought into view.

Thrombosis of Mesenteric Artery.—The case reported by Cawadias and Catsaras presents two points of special clinical interest: first, it is a remarkable example of a pluriarterial syndrome; the aorta, coronary, iliac, femoral and mesenteric arteries showed arteriosclerosis. The patient's first symptoms were those of intermittent claudication, pointing to stenosis of the iliac or femoral arteries; later, he suffered from angina pectoris, due to an aortic or coronary lesion, and lastly, he died from intestinal infarction, terminal syndrome of arteritis of the mesenteric artery. Symptoms of intestinal arteriosclerosis (paroxysmal abdominal pain, colic stasis) were absent, and this lesion manifested itself only in its terminal syndrome, the intestinal infarction. The second interesting clinical point was that diagnosis was made during life. There was absence of hematemesis and sanguinolent diarrhea—symptoms considered characteristic of this affection. The diagnosis was based on the fact that the patient showed an acute peritoneal syndrome, and had a long history of atherosclerosis with clinical arterial manifestations. Hemorrhagic infarction of the intestine is produced even in the absence of alterations of the small blood vessels, by obstruction of a sufficiently large artery. The arterial ischemia and the venous stasis resulting from this obstruction impair the defensive mechanism of the intestinal mucosa and promote multiplication and augmentation of the virulence of the anaerobic bacilli which determine necrosis. The gangrenous necrosis in this case was a real gas gangrene.

Treatment of Tongue Carcinoma.—Paterson suggests that in cases of carcinoma of the tongue the growth be removed by the actual cautery; three weeks later the glands in the neck are removed in the usual way.

Spontaneous Rupture of Heart.—The predisposing cause of rupture in Ley's case was old age, the patient being 85 years of age, with a fatty heart. There could hardly have been any great exertion.

Traumatic Rupture of Aorta.—Kemp's patient was struck on the head and chest by a portion of a stone flywheel which had separated while revolving at full speed in a motor works. He had a large abrasion over the sternum, an abrasion over the right malar bone, and an incised wound of the chin. Postmortem findings in the thorax were: An extravasation of blood into the subcutaneous tissues, and underlying the pectoralis major, an area of abrasion, and an extravasation of blood into the anterior mediastinum. The sternum was fractured obliquely from above downward and backward at the level of the third and fourth costal cartilages. The lungs were deeply congested. The pericardium was greatly distended with blood which had escaped from a transverse tear of the aorta, just beyond the line of the aortic valve. The exuded serum was under considerable pressure. Beyond a firm adhesion of pia mater to the dura over the upper part of the right posterior segment of the cerebrum, nothing abnormal was detected in the cranium.

Medical Journal of Australia, Sydney

1: 337-364 (March 31) 1923

Bacillary Dysentery in Children. F. H. Beare.—p. 340.

1: 365-392 (April 7)1923

Pioneer Australian Surgeon and His Times. N. J. Dunlop.—p. 367.
Echinococcus Multilocularis: What is Meant by This Term? I. C. Ross.—p. 372.
*Case of Sarcoma of Mesentery. G. Bell.—p. 375.
Pathological Report. K. Inglis.—p. 378.

Sarcoma of Mesentery.—Bell's patient, a man, aged 25, noticed a lump in his abdomen which had grown very rapidly. Symptoms were few in number and not bothersome. A large, rounded abdominal tumor was visible, lying for the most part in the right "lower abdominal quadrant" and occupying portions of the right iliac, lumbar, umbilical and hypogastric regions and extending a short distance to the left of the middle line and above the level of the umbilicus. A lateral anastomosis was made between the transverse colon at a point somewhat to the right of its midpoint and the small intestine at the situation nearest the tumor where the circulation was normal. The cecum, ascending colon, hepatic flexure, a small portion of the transverse colon and 237.5 cm. (93½ inches) of ileum were excised, together with the tumor. The blind ends were buried. The patient complained of diarrhea at times during convalescence, four being the maximum number of motions passed in twenty-four hours. Four months after the operation the patient was working at his trade and had gained 3.5 kg. in weight.

Practitioner, London

110: 273-340 (April) 1923

*Diverticulitis of Sigmoid. M. A. Anderson and E. P. Scott.—p. 273.
Recognition of Hemianopsia in General Practice and Its Diagnostic Importance. R. T. Williamson.—p. 276.
Recent Work on Nervous Diseases. H. C. Thomson.—p. 283.
Aseptic Medicine. W. Watson.—p. 291.
Plea for More Frequent Resort to Hysterectomy in Treatment of Chronic Pelvic Disease. J. Phillips.—p. 307.
Uterine Cervical Polypi. A. E. Chisholm.—p. 320.
*Case of Full Term Intraperitoneal Pregnancy, Following Tubal Abortion. E. J. L. Jones-Evans.—p. 328.
*Endocarditis with Gangrene of Both Legs and Infarct of Lung. J. Hirschmann.—p. 331.

Diverticulitis of Sigmoid.—In the case cited by Anderson and Scott, there was a fairly clear history of abdominal trouble for twenty years. The main symptoms were constipation and pain in the left iliac fossa. There was no vomiting. The attacks occurred more or less regularly for ten years, and then there was no further trouble, except constipation, until two years ago, when the symptoms again recurred. The constipation in all these attacks was very obstinate, and the abdominal pain did not disappear as soon as the constipation was relieved, but did so some days later. On rectal examination, a mass could be felt bimanually, and seemed to be situated in the region of the sigmoid flexure. On sigmoidoscopy, the mass could not be seen. On opening the abdomen, the mass was found to be of chronic inflammatory origin, the result of diverticulitis of the sigmoid flexure, which was evidently of long standing, the intestine being firmly adherent to the bladder and threatening to perforate into this viscus at an early date, and there were adhesions also to the pelvic wall. The diverticula were numerous and filled with fecal concretions (stones) which were pressed back into the sigmoid, leaving the diverticula empty. As it was not possible to resect the affected portion of the colon, the adhesions were dissected from the bladder, and the whole of that part of the intestine in which diverticula were present was wrapped up in the great omentum, which was stitched so as to form a covering, thus shutting off the sigmoid from the general abdominal cavity and avoiding the risk of general peritonitis, should any of the diverticula rupture, or the formation of further adhesions to surrounding structures. The patient made an uninterrupted recovery.

Full Term Intraperitoneal Pregnancy.—There was no clinical history pointing to a condition of ectopic gestation in Evans' case. For three weeks before coming to the hospital, the patient had had several slight, intermittent, vaginal hemorrhages, accompanied by a foul mucopurulent discharge. She also complained of obstinate constipation and a sensation of weight and fulness in the rectum which was worse when she was in the prone position. For three or four days she had had attacks of intermittent abdominal pain, somewhat similar in severity to those of labor. A large swelling in the abdomen, corresponding to a uterus at term, was present, extending from the pubes to the ensiform cartilage. By the clinical signs present, it was considered that the patient was carrying a child which had been dead presumably for about two months, and that the gestation was extra-uterine. The patient died. The peritoneal cavity was filled with a foul yellowish fluid, and the peritoneum itself was gangrenous in parts. In the left half of the abdomen, extending well across the midline, was a large gestation sac which was partly decomposed. On opening this, a fully developed fetus was found in a state of commencing decomposition. The placenta was firmly adherent to loops of small intestine and to a portion of the transverse and descending colon, and to the anterior wall of the stomach. There was a large, ragged, necrosed perforation, surrounded by inflammatory lymph, in the transverse colon near the splenic flexure. The placenta itself was in a necrosed condition. The chorion and amnion were completely adherent and could not be separated. There

were one or two perforations in the gestation sac. The fetal head occupied Douglas' pouch.

Endocarditis with Gangrene of Legs.—Hirschmann relates the case of a woman, aged 32, a victim of heart disease, who had pain in the left side of the abdomen, and had vomited that day. She was very constipated. She had a temperature of 101 F. Her chest was normal. An enema was given and the pain in the abdomen disappeared, giving place to one in the left side in the midaxillary line high up. At this place there was dulness on percussion, and signs of pneumonia, with a temperature of 100 F. A week went by normally; the dulness disappeared and she coughed up a small portion of congealed blood. That night she was seized with a violent pain in her right leg, first in the lower end of Hunter's canal and soon after by a similar pain in the popliteal fossa of the left leg. Next day, both legs showed signs of gangrene. The right leg had black marks from Hunter's canal to the knee and was altogether black from the knee down. The left leg was only black in the lower two-thirds below the knee. Amputation was suggested but refused. The patient died from exhaustion and autointoxication.

Quarterly Journal of Medicine, Oxford

No. 63: 173-282 (April) 1923

*Sequelae of Epidemic Encephalitis in Childhood; Prognosis as Regards Complete Recovery. G. H. Anderson.—p. 173.
Cholesterol Content of Blood in Anemia, and Its Relation to Splenic Function. W. MacAdam and C. Shiskin.—p. 193.
*Quinidin in Treatment of Auricular Fibrillation. A. E. Clark-Kennedy. —p. 204.
*Variations in Threshold in Renal Glycosuria. G. Graham.—p. 236.
Hematocrit Volume-Color Index. G. Rossdale.—p. 245.
*Endocarditis Lenta. H. J. Starling.—p. 263.

Sequelae of Epidemic Encephalitis in Childhood.—From a study of forty cases of lethargic encephalitis in childhood Anderson has come to regard disturbance of sleep sequence, psychic changes, and the development of troublesome habits as the most frequent sequelae. Chorea, when present, almost invariably developed during the acute or primary stage of the disease, but tended to recur in combination with the various sequelae for long periods after apparent recovery. Paralysis of cranial nerves was not uncommon during the acute illness, but never recurred, and in all the cases tended either to improve or remain stationary. Typical parkinsonian tremor developed in only one case, but a masklike expression, in some cases accompanied by slow scanning speech, without other symptoms of paralysis agitans, was of frequent occurrence. Disturbance of sleep occurred in twenty-six of the thirty-three nonfatal cases, and persisted for periods of from four months to four years. The large majority of the children suffered from the disturbance for at least two years, and in many instances were the subjects of psychic changes or mental impairment at the end of that time. Psychic disturbances developed in twenty-five of the patients, and consisted usually in a complete change of disposition, of which the main characteristics were disobedience, excessive irritability, and unprovoked fits of temper, cruelty to relatives and to animals, destructiveness, emotionalism, and, more rarely, kleptomania. The change in disposition was seldom accompanied by any marked degree of mental impairment. Definite mental impairment ensued in ten of the children, all of whom showed a striking freedom from the psychic disturbances characteristic of the badly behaved group. Of the troublesome habits which developed as a result of lethargic encephalitis, spitting and hysterical or hyperpneic breathing were the most frequently encountered. None of the children suffering from habit peculiarities has recovered, though some have been under observation for more than two years.

Quinidin in Auricular Fibrillation.—In forty-five unselected cases of auricular fibrillation, the patients being under 65, normal rhythm was restored by quinidin in thirty-seven cases. A standard system of dosage is described. A thorough course of digitalis prior to quinidin treatment is advised, but the simultaneous administration of the two drugs is not recommended. The ill effects of quinidin administration are discussed, and classified into (1) general, (2) embolic, (3) cardiac, (4) cerebral, (5) respiratory. One case of sudden death attributable to quinidin treatment, but not to embolism, is reported. The quinidin treatment of auricular fibrillation is not advised during the acute stage of exophthalmic goiter. It may, however, be applied with beneficial results during the chronic stage of the disease or after thyroidectomy. The best therapeutic results were obtained in rheumatic cases with mitral stenosis rather than in degenerative cases with aortic incompetence or without valvular lesions. After the restoration of normal rhythm the prophylactic administration of quinidin has been continued indefinitely. Relapse has hitherto occurred in the minority of patients only, who were discharged from hospital with normal rhythm persisting. The indications for quinidin treatment are discussed in detail.

New Type of Renal Glycosuria.—A new type of renal glycosuria is described by Graham in which no sugar can be detected in the urine when the patient abstains from food for a short while, but in which sugar is excreted in the urine when carbohydrates are eaten. The sugar tolerance, i. e., the height to which the level of the blood sugar rises after a dose of sugar, is normal. These patients form an important link between normal people and patients with a typical renal glycosuria.

Endocarditis Lenta.—Starling again calls attention to endocarditis lenta, a type of infective endocarditis which occurs in persons of fine health and physique who have had little or no previous illness. The majority of those suffering from it have undergone a considerable degree of physical stress, e. g., those who were serving in the fighting line in the years 1916-1917. It is marked by an insidious onset, very slow progress, long duration, and, as far as is known, a fatal termination. Rheumatic fever is not a determining cause of its occurrence, nor is there any infective agent known as its predisposing cause, except, perhaps, sepsis in the form of impetigo, boils, or wounds. It may be present in a well developed stage without the subject being in any way incapacitated for work. In such a case, the patient may die from the results of a massive embolus without having been aware that he had any disease of his heart. Its course may be afebrile throughout. Pyrexia, when it does occur, is usually the result of emboli. Recovery is suspected to have occurred, but there are no definite proofs. The infection is primary in the endocardium. The postmortem appearances show evidences of infection, reaction, and healing, but no evidence of previous rheumatic endocarditis. It represents the dividing line between rheumatic endocarditis and other forms of infective endocarditis. It resembles the former in its slow progress, formation of fibrous tissue, and evidences of healing, absence of necrotic change in the areas of infarction, and apyrexia. It differs greatly from rheumatic carditis in the frequent occurrence of emboli, in the absence of myocardial infection, in its fatal termination, and in the marked changes in the structure of the valves. The infection is due to a streptococcus of very low virulence which can only infrequently be cultured from the blood, and can be found only with difficulty in sections through the affected endocardium. Its presence, even in an advanced stage, is so insidious that it frequently escapes recognition.

South African Medical Record, Cape Town

21: 145-168 (April 14) 1923

Action of Vaccines. J. P. Johnson.—p. 146.
"Acute Abdomens." G. A. E. Murray and A. Frew.—p. 153.
Parting of Ways. S. M. De Kock.—p. 157.
Prostatectomy. E. B. Fuller.—p. 159.

Annales de l'Institut Pasteur, Paris

37: 329-442 (April) 1923

*Diagnosing a Pathogenic Micro-Organism. M. Nicolle and E. Césari. —p. 329.
*Leprosy in Man and Lepra in Rats. E. Marchoux.—p. 342.
*Cholera Vibrio in Animal Organism. G. Sanarelli.—p. 364.
*Importance of Metal Salts in Immunization. Walbum and Mörch.—p. 396.

Microbiology.—Nicolle and Césari remark in the course of this review of the technic of microbiologic research, that bacteria have to be classified not only by their general characteristics and their pathogenic properties (which include the

power of secreting a specific poison, and the power of proliferating in the attacked organism, the virulence. This last alone is the true meaning of virulence), but by their power to induce production of antibodies. When one usual characteristic is missing, it may be merely a transient loss, and it may reappear spontaneously sooner or later, or the reappearance may be hastened by changing the medium or using larger doses or more susceptible animals.

Rat Leprosy in Man.—The necropsy findings in a young man from Haiti failed to confirm the diagnosis of leprosy which had been assumed from the clinical picture. Marchoux found an acid-fast bacillus in the tissues which transmitted the disease to rats but not to guinea-pigs or rabbits. This excluded any connection with the tubercle bacillus. The bacterium occurs in the form of masses of fine dust, and Marchoux suggests the tentative name of *Mycobacterium pulviforme*. In rats it induced the typical clinical picture of rat leprosy, and he is inclined to regard the case as an instance of the transmission of rat leprosy to man. In the rats, by the fifth month of passage, the pulviform aspect changed to the bacterial shape.

Portals of Entry and Exit of Cholera Vibriones.—This is Sanarelli's seventh publication on the pathogenesis of cholera. Whatever the portal of entry of the vibriones in rabbits and guinea-pigs, they find their way promptly to the intestinal wall. The vibriones are destroyed in the stomach of the adult rabbit and guinea-pig, but when spread on the mucosa of the mouth or insufflated into the nasopharynx or inoculated into the peritoneum, they rapidly pass to the intestinal wall.

Enhanced Production of Immune Serums Under Influence of Metal Salts.—Walbum and Mörch state that the production of diphtheria antitoxin has been materially increased at the state Serum Institute at Copenhagen since the practice has been adopted of giving the animals intravenous injections of manganese chlorid. They review the research in Denmark and elsewhere which has demonstrated the importance of the metal salts in immunization in general, and particularly in increasing the potency of diphtheria antitoxin and of agglutinins for the colon bacillus. The antitoxin production increases immediately and reaches its height in an hour; the difference is thus fundamental between the effect of the salt and of the injection of toxin. The latter is followed by a drop in antitoxin production (first negative phase). Manganese chlorid by the mouth has no effect. Certain other metal salts act in the same way but in a less degree.

Bulletin Médical, Paris

37: 477-504 (April 28) 1923

*Indications for Operation with Intestinal Stasis. M. Robineau.—p. 483.
*Rectopelvic Constipation or Dyschesia. A. C. Guillaume.—p. 485.
*Etiology of Intestinal Stasis. J. Dalsace.—p. 495.

Intestinal Stasis.—This is the second issue of the *Bulletin* devoted to the study of constipation. Robineau insists that operative measures to relieve intestinal stasis are palliative. They do not restore conditions to normal; but even the partial benefit justifies them.

Rectopelvic Constipation.—In the course of this study of dyschesia and the hygiene of the bowels, Guillaume warns that the bladder motor function is intimately connected with the defecation function. Repression of desires to urinate may have a depressing influence on the rectal reflexes similar to repression of desires for defecation. His charts illustrate the mechanical advantages for defecation when the abdomen and thighs are in contact. The narrower the angle formed by the axes of the trunk, thighs and legs, the better for defecation. The modern toilet conflicts with this rule of hygiene, as the angles are nearly right angles.

Etiology of Intestinal Stasis.—Dalsace explains that intestinal stasis is often traceable to chronic appendicitis or disease of the cecum or colon. Radioscopy, horizontal and vertical, is indispensable in the examination; systematic medical treatment is indicated whether indications call for operation or not.

Bulletins de la Société Médicale des Hôpitaux, Paris

39: 183-237 (Feb. 9) 1923

*Cytology of Gonorrheal Arthritis. A. Lemierre et al.—p. 184.
*Pathologic Physiology of Cancer Patients. Renaud.—p. 192.
*Glycolysis in Diagnosis of Gastric Cancer. Ramond et al.—p. 195.
*Autolysis in Diagnosis of Gastric Cancer. Ramond and Zizine.—p. 196.
Treatment of Gonorrheal Arthritis. Ramond et al.—p. 200.
First Case of Sodoku Observed in Turkey. Mouchet and Guillermin. —p. 202.
Unilateral Argyll Robertson Sign with Symptoms of Rachitis. Frenkel and Stillmunkes.—p. 204.
Disturbances of Respiration, Sleep and Character in Girl Aged 9 with Encephalitis. Urechia and Mihalescu.—p. 210.
Uselessness and Cure of Morphinization in Chronic Affections. M. Renaud.—p. 215.
Histopathology of Paraleprous Ainhum. Delamare and Achitouv.—p. 218.
Paralysis of Convergence After Encephalitis. C. Vincent and E. Bernard.—p. 222.
Modification of Measles by Preventive Injection of Convalescent's Serum. R. Debré and J. Ravina.—p. 226.

Cytology of Exudates in Gonorrheal Arthritis.—Lemierre, Piédelièvre and Levesque publish two observations of therapeutic failures with intra-articular injections of antigonococcus serum. The local reactions were very severe, but the polynucleosis of the exudate did not change into a prognostically favorable monocytosis.

Evolution of Cancer and Pathologic Physiology of Carcinomatous Patients.—Renaud points out that all present reactions for cancer do not indicate anything except cachexia, which may be due to other causes.

Glycolysis in Blood of Patients with Carcinoma of the Stomach and Its Possible Diagnostic Value.—Ramond, Parturier and Zizine, in four patients with carcinoma of the stomach, found retardation of glycolysis of the incubated blood, similar to that Lépine found in diabetes. Cachexia may behave in a similar way, but these patients were still strong. In the discussion, Achard reported that the reaction is not always present in carcinoma, and that it has no connection with localization in the intestinal tract.

Determination of Autolytic Products in Early Diagnosis of Carcinoma of Stomach.—Ramond and Zizine found an increase in amino-acids and polypeptids in blood and urine of carcinomatous patients. The proportion of amino-acid nitrogen to total nitrogen of the urine was 3½ times greater than in normal subjects. They explain these findings by autolysis of the carcinoma, and emphasize the necessity to exclude in diagnosis other conditions (rapid loss in weight, acidosis, internal suppurations and fever) which may cause identical changes. In the debate, Loeper confirmed these findings but did not believe that they—any more than deficient glycolysis—could lead to discovery of small tumors.

47: 403-458 (March 16) 1923

*Unilateral Hippocratic Fingers. J. Hatzieganu.—p. 403.
*Origin of Encephalitic Sequelae. Chiray and Lafourcade.—p. 406.
*Venous Pulse in Goiter. Sainton and Mougeot.—p. 415.
Perisigmoiditis Located by Radiography. De Jong and Aubourg.—p. 423.
*A Case of Toxic Meningitis. P. Gautier.—p. 429.
Myoclonic Epidemic Encephalitis in Infant. Barbier and Célice.—p. 432.
Partial Congenital Gigantism. Gandy and Boulanger-Pilet.—p. 431.
"Sheathing Osteitis" of the Diaphyses. P. Sainton et al.—p. 439.
Erosive Pluriorificial Ectodermosis. N. Fiessinger et al.—p. 446.
Aneurysmatic Compression of Vena Cava Superior. Chiray and Lebon. —p. 449.

Hippocratic Fingers with Aneurysm of the Brachiocephalic Trunk.—Hatzieganu has observed two cases which confirm that combination of venous stasis and toxic influences from infection are the cause of this affection. Their coexistence may determine either unilateral or bilateral hippocratic fingers.

Epidemic Encephalitis with Respiratory, Bradytrophic and Psychic Sequelae.—Chiray and Lafourcade are of the opinion that the three types of sequelae in the case described constitute the manifestations of the encephalitic virus from a single focus, an inclusive polioencephalitis of the base. This seems more plausible than that the symptoms are attributable to a triple manifestation of the same virus in remote regions of the brain. The latest experiences have shown that the virus in a nerve center is not always destroyed but is frequently capable of resuming activity after months or years.

In the case here described, this resumption of activity recurred four times in twenty months, the intervals being two, one, five and twelve months.

Venous Pulse and Apex Tracings in Exophthalmic Goiter.—Sainton and Mougeot, on the basis of the jugular and apex tracings in nine patients with exophthalmic goiter, have come to the conclusion that: (1) The intracardiac conductility is exaggerated, the auriculoventricular interval is shortened (positive dromotropic action of the sympathetic); (2) the duration of ventricular diastole is shortened in relation to that of systole and the cardiac revolution (chronotropic action of the sympathetic); (3) the down Y curve in the jugular tracing disappears as a result of the brevity of the ventricular diastole; (4) certain morphologic modifications of the cardiogram appear to be an early sign of functional weakness of the ventricle.

A Case of Toxic Meningism.—Gautier reports a case of severe meningism, with increase in the number of cells, in a boy with a tenia solium.

Gynécologie et Obstétrique, Paris

7: 273-368 (April) 1923

*Accidents of Tubal Pregnancy. Lenormant and Hartmann-Keppel.—p. 273.
*Pyosalpinx Opening into Rectum. A. Chalier and Vergnory.—p. 294.
*Embryomas of Fallopian Tubes. E. Delannoy.—p. 301.
Primary Epithelioma of Tube. A. Guillemin and R. Morlot.—p. 326.
*Hemorrhage in Nerve Centers in Eclampsia. Levant and Portes.—p. 332.

Ruptured Tubal Pregnancy.—Lenormant and Keppel review a recent series of accidents with tubal pregnancy, which brings their record to 87. The mortality was only 10.7 per cent., although the majority reached the hospital with extreme anemia or advanced infection. In one case posterior colpotomy was made on a mistaken diagnosis. It was immediately followed by laparotomy.

Pyosalpinx Spontaneously Perforating into the Rectum.—Two cases are reported, and it is emphasized that there is no need to seek and suture the perforation; if necessary a fragment of the pus pocket can be left adherent to the rectum at the laparotomy. A perisalpingitis with fistula may heal, but a pyosalpinx opening into the rectum never does as the content of each cavity sets up inflammation in the other. Abdominal hysterectomy is the only treatment; both adnexa are generally involved, and a conservative operation is inadvisable.

Embryomas of the Tubes.—Delannoy found a dermoid cyst in one tube and a mixed tumor in the other tube of the woman aged 32. He has compiled nine cases of embryomas of the tubes which he summarizes. Cancer in these tumors has never been noted, and no complications have been reported.

Hemorrhage in the Nerve Centers in Puerperal Eclampsia.—Levant and Portes give the details of forty-six fatal cases of cerebral hemorrhage in the course of eclampsia. The list includes a few unpublished cases. In some of the cases the hemorrhage occured with mild eclampsia, but with high blood pressure; this teaches the necessity for prophylactic venesection. At the Baudelocque clinic there have been 183 cases of eclampsia, since 1893, in a total of 55,488 childbirths, 2.7 per cent., of the eclampsia cases terminated in cerebral hemorrhage.

Journal de Chirurgie, Paris

21: 401-528 (April) 1923

*Congenital Pseudarthrosis. Dujarrier and Perrin.—p. 401.
*Reconstruction of the Face. P. Moure.—p. 414.
*Muscular Angiomas. Mondor and Huet.—p. 423.
*Surgical Treatment of Elephantiasis. C. Lefebvre.—p. 434.

Congenital Pseudarthrosis.—Dujarier and Perrin present four cases to confirm the excellent results attainable with Delagénière's bone-periosteum grafts in the curable forms of congenital pseudoarthrosis. When the congenital bone defect is very extensive, and there is much atrophy of muscles, more complicated procedures are required. They report one case in this category, still under treatment to remedy the arrest in development.

In the others, the osteoperiosteal grafts answered the purpose admirably; the cure was complete in two months in three cases and in five or six months in the others.

Reconstruction of the Face.—Moure extols the advantages of taking the flap to reconstruct the mouth region from the scalp and rolling the long pedicle into a tube brought down over the face to the spot. He sutures the skin to form the loose tube and when the flap has healed in place, the tube is cut away from the flap, and the tube is opened and sutured back in its natural place. The tube pedicle insures unhindered nourishment of the flap. In one of the three cases illustrated, the tube pedicle extended from between the shoulders to the cancer on the cheek and chin; it had developed after radiotherapy of lupus. If growth of hair is not desirable, he slices off the hair follicles on the under side of the flap, before fitting it in place.

Muscular Angiomas.—Mondor and Huet remark that the importance of these growths lies in the fact that the correct diagnosis was scarcely ever made in the 164 cases he has found recorded. The severe hemorrhage as the supposed lipoma or cold abscess was being removed gave the first suspicion of its true nature.

Elephantiasis.—Lefebvre reviews the outcome of measures to divert the lymph in elephantiasis of the limbs. In 26 cases in which Handley's diversion of the lymph into the subjacent tissues was applied, none of the patients was completely cured at the time or later. In the 28 cases treated by drainage into the deep connective tissue, the results were excellent, especially with the Kondoleon method. The extensive excision of tissue does no harm. In one case he applied the Kondoleon on one side and the Walther mixed method on the other. The tissues were softer after the Walther procedure, which seemed in other ways to be superior to the Kondoleon.

Lyon Chirurgical

20: 1-126 (Jan. and Feb.) 1923

*Embolectomy. E. Key.—p. 1.
Fractures of Acetabulum. J. Cottalorda.—p. 32.
*Fracture of Neck of Femur. Charbonnier.—p. 43.
*Traumatic Injury of Children's Wrists. R. Massart and P. Cabouat.—p. 67.
*Adamantine Cyst. P. Santy and C. Dunet.—p. 89.
Megacolon in Children. F. Perrenot.—p. 95.

Embolectomy.—Key's experience was mentioned in these columns, March 18, 1922, p. 855. He has slit the artery to remove the embolus in 9 cases, with a bilateral operation in one case. His first case in 1912 was, he says, the second completely successful instance of embolectomy on record. Thrombosis of the heart or occasionally of the aorta was the usual source of the embolism, although there may have been no symptoms to attract attention to the heart. The youngest patient was 12, the oldest 72. The embolus generally lodges at a bifurcation, but the collaterals may maintain the circulation so that the circulation does not become arrested until some distance below. Consequently the embolus is sought too far down as a rule. Pulsation may persist in a thrombus just below the embolus. The latter is usually only 2 cm. long, but secondary thrombosis may enlarge it. Multiple embolism occurred in 7 of his 9 cases, and in 5 cases two emboli were found on the same side. The interval ranged from two hours to four days. Gangrene developed in 4 cases, fatal in one. He has compiled 51 other cases of embolectomy from the records. Of the 16 successful cases (of 36 in which the time is mentioned), the interval was from sixteen to twenty-four hours in 3.

Fracture of Neck of Femur.—Charbonnier places a knitting needle on the sound hip joint, extending from the anterior superior iliac spine to the spine of the pubis, through the fundus of the acetabulum. A second knitting needle corresponds to the neck of the femur, and a third needle, from pubis to this second needle, completes the triangle formed by them. The ends of the knitting needles fit into corks, and another cork, slipped on the neck needle, is fastened 2.5 cm. below the cross bar to show the center of the head. The needle triangle is then transferred to the fractured side, and guides the screw driven the length of the neck into the exact center of the head. It shows the length of the screw required,

and the amount of shortening of the limb to be corrected. Twenty-four illustrations are given.

Traumatism of the Wrist in Children.—Massart and Cabouart analyze the ultimate outcome in eighty-eight of 377 cases of injury of the wrist. Even slight trauma may entail grave lesions of the epiphysis, while grave trauma is often followed by perfect repair. They abhor operative measures on children's fractures, but old crippling deformity may require wedge resection.

Adamantine Cyst.—In Santy and Dunet's case the uniocular cyst in the lower jaw of the man aged 52 was accompanied by intraparietal microcystic formations.

Presse Médicale, Paris

31: 373-384 (April 25) 1923

*Diagnosis of Syphilis in Infants. A. B. Marfan.—p. 373.
*Periodicity in Vegetative Nervous System. D. Santenoise.—p. 375.
*Congenital Hydronephrosis. H. L. Rocher and R. Darget.—p. 377.
*Drug Dissociation of Vital Centers. R. Soupault.—p. 379.

Diagnosis of Congenital Syphilis in Infants.—Marfan lists five manifestations of congenital syphilis any one of which clinches the diagnosis. The first three, pemphigus of palms or soles, a special coryza, and enlargement of the spleen are found at birth or soon after. The other two, syphilids and Parrot's disease, may not develop at once but are usually manifest by the fourth month.

Periodicity in Vegetative Nervous System.—Santenoise has found the oculocardiac reflex, the hemoclastic crisis, the solar reflex and certain drug tests instructive in examining the vegetative nervous system. He has thus demonstrated that in periodic psychoses the balance in the vegetative nervous system is seriously upset. Symptoms of vagotonia accompanied paroxysms of acute mania or psychoses of dread.

Congenital Hydronephrosis.—The condition was not recognized till the age of 9 when the child was being examined for gastro-enteritis. Recovery followed nephrostomy with secondary nephrectomy.

Dissociation of Bulbar Centers by Procain.—Soupault reports a case in which intraspinal anesthetization with procain arrested completely the functioning of the respiratory center. The blood pressure and circulation were only very slightly modified. Under artificial respiration the drug was eliminated enough so that the paralysis of the respiratory center was finally overcome, and natural respiration began anew the forty-fifth minute. This confirms on man the dissociation of the bulbar centers realized in dogs by injection of chloralose into the region. In the animals and in this clinical case, consciousness was unimpaired. The man complained that the pressure on the ribs hurt him, and the dogs dodged when threatened with a blow. As the patient resumed spontaneous but sluggish respiration, a brief convulsion occurred, and recurred six or eight times in the following four hours. Soupault interprets the convulsions as indicating that respiration was not adequate at first. The whole experience teaches the importance of artificial respiration in mishaps with anesthetics. Instead of wasting time on other measures, artificial respiration should be started at once, and kept up regularly as long as needed.

31: 385-396 (April 28) 1923

Fibromas Complicated with Pregnancy. Brindeau.—p. 385.
Acute Phase of Large Abscesses of Liver. Combier and Murard.—p. 386.
Fibrous Mesenteritis at Sigmoid Flexure. A. Lesniowski.—p. 388.
Infectious Sarcoma in Fowls. G. Roussy and M. Wolf.—p. 391.

31: 397-404 (May 2) 1923

*Treatment of Dropsy. A. Lemierre and J. Lévesque.—p. 397.
*Gage for Retraction of Blood Clot. A. Hustin.—p. 400.

Treatment of Grave Edema.—Lemierre and Lévesque report some new instances of the shifting of the fluid from the subcutaneous edema into the peritoneum or pleura after drawing off fluid from these serous cavities. The effusions in them reform at the expense of the edema, and the fluid can then be easily drawn off. In two of six cases described, the edema and pleural effusion accompanied chronic nephritis; in the third case the dropsy and ascites were due to liver disease, and in four other cases heart disease was responsible for the extreme edema. In all, the edema had been refractory to all previous measures, but when salt was restricted and the effusion in the serous cavity was withdrawn, the edema fluid was drawn into the circulation. Once in the general blood stream, the attraction exerted by the serous cavities was greater than that of the subcutaneous tissues, so the fluid settled in them and could be released by tapping. This should be done preliminary to digitalis or theobromin.

Gage for Retraction of Blood Clot.—Hustin uses a paraffined capillary tube, the upper end spreading funnel-wise, as he describes with an illustration.

31: 405-416 (May 5) 1923

*Signs of Syphilis in Infants. A. B. Marfan.—p. 405.
Parasynovial Tuberculoma of the Knee. X. Delore.—p. 408.
Early Diagnosis of Acute Appendicitis. R. Rove.—p. 409.
*Iodin in Treatment of Rebellious Malaria. L. Cheinisse.—p. 410.

Diagnosis of Syphilis in Young Infants.—Marfan reviews five data obtainable from the mother which suggest the probability of syphilis (including a history of twins or hydramnios), and fifteen data from the child itself (including certain forms of rachitis, malformations, anorexia, habitual vomiting and early adenoids). Even when there are no certain signs of syphilis, and the Wassermann reaction is negative, if syphilis is suspected, he advises managing the case as if the disease was certain.

Malaria Rebellious to Quinin.—Roubachkine calls attention anew to the efficacy of iodin internally in treatment of malaria that has proved refractory to quinin. The iodin does not kill the parasites but it seems to ward off the febrile attacks and to reactivate the quinin. He gives from 5 to 10 drops of a 10 per cent. tincture of iodin twice daily, or with iodid, or with quinin. Cheinisse quotes other experiences in this line, one dating from 1846.

31: 417-428 (May 9) 1923

*Blood Count During Roentgen Irradiation. Trémolières et al.—p. 417.
Hydrocele in Infants. P. Vallery-Radot and Salès.—p. 420.

Improvement in Blood Picture During Radiotherapy of Pulmonary Tuberculosis.—Trémolières confirms the finding that mild roentgen irradiation of the spleen and bone marrow stimulates blood production. The response seemed to be almost as pronounced in the tuberculous as in normal subjects.

Revue Française d'Endocrinologie, Paris

1: 3-96 (Feb.) 1923

Origin and Progress of Endocrinology in France. E. Gley.—p. 3.
*Acute Insufficiency of Suprarenal Capsules. Sergent and Oury.—p. 19.
*Senility and Hypertrophy of Suprarenal Capsules. J. Sabrazès and P. Husnot.—p. 31.
Hormones and Sex-Linked Heredity. L. Cuénot.—p. 41.
Transplantations of Endocrine Glands. Mauclaire.—p. 58.

Acute Insufficiency of Suprarenal Capsules.—Sergent and Oury publish a new observation, with necropsy findings, in which the correct diagnosis was made clinically. The patient had suffered for seven years from chronic insufficiency of suprarenal capsule (pigmentation, asthenia, low blood pressure) and was treated by extracts of suprarenal capsules. He never had the "white line" sign. He died in an acute attack of abdominal pain, painful muscular spasms, and even contractures, low blood pressure and temperature and vomiting. The suprarenal capsules were extremely atrophied, and contained tubercles.

Senility and Hypertrophy of Suprarenal Capsules.—Sabrazès and Husnot report a case, and believe that adenomatous hypertrophies of suprarenal capsules, which are frequent in old persons, may cause a "hyperepinephry" leading to high blood pressure and arteriosclerosis.

Schweizer Archiv f. Neurol. u. Psychiatrie, Zurich

12: 1-176, 1923

Psychology of Aphasia. C. F. van Valkenburg.—p. 1.
*Research on Cerebellum Function. Rossi and Simonelli.—p. 28.
*Heredity of Mental Disease. F. and E. Minkowski.—p. 47.
Anatomic Connections Between Circonvolutions. Minkowski.—p. 71. Cont'd.
*Aphasia. A. Pick.—p. 105. Cont'd.
*The Difficulty of Intellectual Processes. W. Eliasberg.—p. 136. Cont'd.
Mania in Dementia Praecox. R. Benon.—p. 165.
*Homosexuality and Sadism. T. Witry.—p. 169.

Research on Cerebellar Function.—Rossi and Simonelli conclude from their research on dogs and what others have published, that surgical lesions of the cerebellar cortex alone are enough to produce the characteristic functional disturbances. The results of galvanometric studies have been discredited by the discovery that the effect of the electricity is felt beyond the cerebellum. Rossi has studied the effects of simultaneous stimulation of the cerebral and cerebellar cortex, and has thus learned a number of fragmentary data which serve at least to show the gaps in our knowledge and guide further research. They say that the results of his research afford the first experimental proof of the functional relations between the cerebellum and the corticospinal system. The cerebellum seems to facilitate the action of the corticospinal mechanisms. This action of the cerebellum is in addition to the postural tone function.

Heredity of Mental Disease.—The research here reported was begun in 1912 and carried on under a special grant. Hereditary conditions in two families were studied from biologic and social standpoints, heredity research and the clinical psychiatric standpoint. Fifty-five members of one family and sixty-two of the other were investigated. The research covers six generations, a total of 391 and 361 members with 21 and 26 with mental disorders. The mental affections are a blend of three types: schizophrenia, alone or with manic-depressive insanity, or with epilepsy. A tendency to what they call schizoidia is also apparent in some branches. Four branches of one family have entirely escaped the taint. They emphasize that the proportion of persons affected has been growing less in the later generations, with none in the present generation.

Aphasia.—Pick discusses aphasia from the standpoint, among others, of the psychology of speech, analyzing a case in which a merchant long living in France, although born in Germany, was unable to think in French any more. He was familiar with Greek and Latin but also developed word blindness for Greek.

Intellectual Processes.—Eliasberg analyzes the psychology and psychopathology of intellectual processes, and their importance for research on mentality and in dementia. He discusses in this instalment the motives and methods of research on intelligence, and the genetic criteria: psychology of animals and children.

Homosexuality and Sadism.—Witry relates that during the war he encountered a number of purely homosexual persons, and found them, in war as in peace, inclined to be amiable and altruistic, as brave and devoted soldiers as any. No abuse of officer's authority was ever noted. He adds that he met three others who displayed a homosexual sadistic tendency.

Schweizerische medizinische Wochenschrift, Basel

53: 349-368 (April 5) 1923

*Etiology of Epidemic Encephalitis. R. Doerr and E. Zdansky.—p. 349.
*Hydrostatic Test of Lung Tissue. S. Schönberg.—p. 351.
Physiology of High Altitudes. S. Hediger.—p. 352.
Studies in Pathology of Heart. E. Attinger.—p. 357.

Etiology of Epidemic Encephalitis.—Doerr and Zdansky believe that Kling's granulomas in the brains of some rabbits inoculated with encephalitis virus are probably due to a parasitic affection of the animals entirely different from human encephalitis. They find that there must be very close relations between the virus of febrile herpes and of epidemic encephalitis.

Necessity of Supplementing the Hydrostatic Test with Microscopic Examination.—Schönberg points out that the floating test with lungs of new born children cannot always prove or disprove previous breathing. Microscopic examination may be valuable in cases in which the lungs sink.

Archivio Italiano di Chirurgia, Bologna

7: 1-112 (Feb.) 1923

Case of Infection with Actinomyces Carneus. G. Crescenzi.—p. 1.
*Autoplastic Reduction of Blood Vessels. F. Nassetti.—p. 18.
*Inguinal Hernia of the Uterus. F. S. Latteri.—p. 39.

Autoplastic Reduction of Lumen of Large Blood Vessels.—Nassetti's technic resembles somewhat Matas' operation on aneurysmal sacs. He applied it to the carotid, aorta, vena cava or jugular vein in eight dogs, and found the results perfect. A long ellipse is cut lengthwise out of the vessel, and the lips of the incision are sutured together. The vessel is thus rendered smaller in diameter by the width of the ellipse excised. The resection of the ellipse is facilitated by four guiding threads. The vessel can thus be reduced to two thirds of its former size without interfering with the flow of blood. The danger of thrombosis is less the larger the vessel and the greater the pressure and velocity of the blood stream.

Hernia of the Uterus.—Latteri gives summaries of 77 cases of hernia of the uterus he has found on record, and describes a case personally observed in a woman aged 36. The hernia was first noticed twenty years before, but it had been small until the last two years. He classifies the cases according to the type of hernia, umbilical, femoral, obturator or inguinal, his research showing that with inguinal hernia of the uterus some congenital deformity is always a factor.

In 11 cases the inguinal hernia was formed by the gravid uterus, and in one in this group it proved possible to reduce the hernia. In 26 cases the uterus was in a male hermaphrodite. There were 2 infants in this group, all but one were cured by reduction or removal of the uterus.

Archiv für Verdauungs-Krankheiten, Berlin

31: 1-126 (March) 1923

Action of Various Substances on the Liver. M. Einhorn.—p. 1.
Physiologic Alimentary Hyperglycemia. M. Elzas.—p. 13.
Viscosity of Gastric Juice in Healthy and Diseased Stomachs. G. Klawansky.—p. 23.
*Ulcers of Stomach and Duodenum. de B. P. van Amstel.—p. 33.
*Necropsy Findings in Vegetarian. E. v. Ammon.—p. 71.
*Drug Treatment of Gastric-Duodenal Ulcers. Glässner and Loew.—p. 95.
Gastric Ulcer and Kidney Function. W. Robitschek.—p. 107.
Sarcoma of Jejunum Causing Retrograde Invagination. Graef.—p. 111.

Covered and Penetrating Ulcers of Stomach and Duodenum.—Amstel pleads not only for immediate operation on perforated ulcers, but for operation on every ulcer. The operation should be followed by atropin treatment, because all these patients are vagotonic. The pain from perforation is so sudden, severe and typical that diagnosis is easy. Even if no gastric symptoms were present before, the surgeon should examine the stomach and duodenum, if he fails to find the perforation.

Necropsy Findings in a Vegetarian.—Ammon publishes the findings in an almost strict vegetarian, and reviews literature. He finds: A lactovegetable diet is sufficient for nutrition. A purely vegetable (without milk or eggs) diet is possible only if the subject exercises a great deal. The diet prevents gout and diminishes fat deposits, but lowers the immunity against purulent infections, and dilates the stomach and colon because of the large amounts of food required.

Pharmacologic Treatment of Gastric and Duodenal Ulcers.—Glässner and Loew give daily about 400 c.c. of a 0.4 per cent. (decinormal) solution of sodium hydroxid, divided into two hour fractions. No strict diet was necessary. There were nineteen clinical recoveries in twenty-five patients treated for three to nine months. Sodium hydroxid destroys the peptic action of the gastric juice, while milder alkalis (sodium carbonate) inhibit it only temporarily.

Deutsche medizinische Wochenschrift, Leipzig

49: 401-432 (March 30) 1923

Pathology and Treatment of Kidney Disease. II. F. Umber.—p. 401.
*Skin and Immunity. F. Klemperer and S. Peschic.—p. 403.
*Heart Action. L. Haberlandt.—p. 404.
Treatment of Sterility of Women. L. Nürnberger.—p. 406. Cont'd.
The Menopause from Clinical Standpoint. H. Wollstein.—p. 409.
Diagnosis and Treatment of Pericarditis. F. W. Strauch.—p. 410.
*Treatment of Gastric Ulcers by Irradiation. O. Strauss.—p. 411.
Late Traumatic Hemorrhage in Brain. C. Goroncy.—p. 413.
Pyramidon Test for Occult Bleeding. F. Hirschberg.—p. 414.
*Fate of Children with Pylorospasm. G. Redlin.—p. 415.
Two Cases of Barbital Poisoning. Herz.—p. 416.
Group Method for Measuring of Constitution. Ascher.—p. 416.
*Uniform Classification in Degrees. Pfleiderer.—p. 417.
Forceps Delivery. M. Henkel.—p. 418.
Births and Mortality in One Province and Mortality of Children in the Netherlands. Prinzing.—p. 420.
Smallpox Statistics of the United States. Sieveking.—p. 421.

Foundations and Aims of a Historic Presentation of the Development of Medicine Since Foundation of Cellular Theory. Diepgen.—p. 421.

Skin and Immunity.—Klemperer and Peschic do not find any indication of a special function of the skin in immunity. Fellner's "procutins" do not exist.

Heart Action.—Haberlandt confirms histologically the degeneration and eventual loss of nerve fibers in the apex of the frog's heart when clamped off by Bernstein's method. Conduction must have been myogenous in these animals.

Treatment of Gastric Ulcers by Irradiation.—Strauss long ago taught the retention of calcium following roentgen irradiation. This and the increase in hydrogen ion concentration may account for transitory subjective improvement in patients with ulcers. The usual doses do not produce changes in the epithelium of the stomach and do not cure ulcers.

Fate of Children with Pylorospasm.—Redlin reports on the later results of nineteen cases of pylorospasm. Three of the children died at the clinic. The prognosis in those who overcame the spasm, is favorable. Yet their inclination to nervous symptoms is so striking that he agrees with Heidolph in considering pylorospasm as part of a spastic-neuropathic diathesis.

Uniform Classification in Degrees.—Pfleiderer pleads for uniform use of five degrees in measuring the strength of reactions and symptoms.

Klinische Wochenschrift, Berlin

2: 573-620 (March 26) 1923

Cholangitis. F. Umber.—p. 573.
*Superinfection in Spirochetal Affections. Buschke and Kroó.—p. 580.
*Pathogenesis of Pernicious Anemia. Moses and Warschauer.—p. 581.
*Number of Blood Platelets and Function of Vessels. Spitz.—p. 584.
*Behavior of Heated Serum. Ehrentheil and Weis-Ostborn.—p. 585.
Bruck's Flocculation Reaction in Syphilis. O. Grütz.—p. 586.
Fatal Injury with Electric Current. Wildegans.—p. 588.
Psychic Troubles in Pituitary Disease. Büchler.—p. 591.
*Two Phases of Epinephrin Action. H. Vollmer.—p. 593.
Quantitative Analysis of Bone Ash in War Osteopathy. Loll.—p. 594.
Paradoxic Increase of Fever After Sodium Salicylate. Kahn.—p. 594.
*Diagnosis and Treatment of Wound Diphtheria. Landau.—p. 595.
Psychopathology of Political, Social and Cultural Conditions. K. Bonhoeffer.—p. 598.
Sedimentation of Erythrocytes. E. Wiechmann.—p. 601.

Superinfection in Spirochetal Affections.—Buschke and Kroó were able to cure experimental recurrens infection in mice with arsphenamin, clinically and hematologically, but some spirochetes persisted in the brain of 70 per cent. of the treated animals. In spite of this a superinfection with the same strain of spirochetes was possible.

Pathogenesis of Pernicious Anemia.—Moses and Warschauer injected extracts of feces prepared according to Seyderhelm, who claimed that they have a hemolytic action in vivo, though not in vitro. They found that these extracts cause only nonspecific variable changes in erythrocytes and leukocytes, the same as other injurious substances. Seyderhelm claims to have found a pernicious type of anemia only in rabbits injected with extracts of mesenteric glands from persons who had died from pernicious anemia, but not from controls. They found similar changes in a rabbit injected with an extract of rabbit's muscles.

Number of Blood Platelets and Function of Vessels.—Spitz considers the relation between the bleeding time and number of platelets a good criterion of the function of capillaries.

Different Behavior of Heated Serum in Carcinoma and Pernicious Anemia.—Ehrentheil and Weis-Ostborn give the technic of the test they devised with Luger. They found that diluted serum from carcinomatous patients heated to 80 C. gives a very weak opacity, while serum from pernicious anemia is more strongly coagulated, than normal serum. Heating serum from pernicious anemia to 100 C. causes marked flocculation and a large sediment when centrifugated, while serum from tertiary syphilis does not flocculate.

Two Phases of Epinephrin Action.—Vollmer, after injections of epinephrin finds a first phase characterized by acidosis, decrease in potassium and phosphates in the blood, hyperglycemia, increased elimination of acids, and a slower metabolism. This phase is followed by an alkaline second phase with exactly opposite changes. The first stage corresponds surprisingly well with symptoms of florid rachitis, the second with tetany. He believes that the changes in phosphates and the hydrogen ion concentration of the blood are leading in the action of epinephrin.

Diagnosis and Treatment of Wound Diphtheria.—Landau examined 170 wounds for diphtheria bacilli. He found bacilli resembling diphtheria in 18.2 per cent. Most were so characteristic that a mere examination of similar bacilli from the throat would have led to the diagnosis "diphtheria." A complete examination, however, showed that not one of these strains was typical. Diphtheroid bacilli are very common in wounds and Loeffler's medium alone is not sufficient for differentiation in these cases.

Medizinische Klinik, Berlin

19: 407-450 (March 31) 1923

*Diastolic Aortic Murmurs. N. Ortner.—p. 408.
Synergetic Actions in Infectious Diseases. E. Abderhalden.—p. 409.
Ulcer of Duodenum. R. Schmidt.—p. 409. Conc'n p. 455.
*Pain with Ulcers of Stomach and Duodenum. O. Porges.—p. 411.
*High Arterial Pressure and Its Treatment. G. Singer.—p. 415.
*Practically Important Types of Syphilis of Joints. H. Schlesinger.—p. 417.
*Low Blood Pressure. J. Pal.—p. 420.
*Myeloid Reaction. N. Jagic and G. Spengler.—p. 421.
Tuberculosis and Pregnancy. Neumann.—p. 422. Conc'n.—p. 461.
*Mercury Diuresis. M. Sternberg.—p. 424.
*After-Action of Galvanic Currents. S. Erben.—p. 426.
*Chromosomal and Incretory Hormones. J. Bauer.—p. 427.
Function of Crista Terminalis. L. Hess.—p. 429.
Case of Peculiar Disturbance of Carbohydrate Metabolism. L. Pollak and R. Wagner.—p. 430.
Extensive Tuberculosis of Organs in No Connection with Alleged Accident. H. Engel.—p. 432.
Stimulants and Heart Tonics. C. Bachem.—p. 433.
Treatment of Syphilis with Bismuth. F. Pinkus.—p. 437.
Periarterial Sympathectomy. K. Singer.—p. 438.

Accidental Diastolic Aortic Murmurs.—Ortner concludes from two cases of pernicious anemia with necropsy findings that accidental diastolic murmurs at the aortal orifice do exist. Since they were due to a degeneration of muscular prominences in the fundus of the valves, he believes that the expression "accidental" (functional) is not correct. Krehl emphasized the significance of these muscles for complete closing of the valve.

Pain Phenomena in Diagnosis and Treatment of Ulcers of Stomach and Duodenum.—Porges found that colic was caused by ulcers, but practically by no other affection of the stomach. Pressure with the palm diminishes the pain. During the pain from ulcers the patient sits with knees drawn up, or lies on his side, pressing his thighs against the abdomen, or lies on the abdomen with a pillow under it. Lessening of the pain after intake of alkalis speaks for ulcer and against spasm. He gives one teaspoonful of a mixture of magnesium oxid and calcium carbonate every two hours. If the patient is constipated, more magnesia than calcium carbonate should be used. The diet eliminates strong spices, too hot and too cold food and fluids, and strong alcoholic beverages. Since the supposedly anacid cases of ulcer have an acid secretion when examined three or four hours after a hearty meal, the same alkaline treatment should be used.

High Arterial Pressure and Its Treatment.—Singer periodically reduces the salt in the food and substitutes bromids.

Practically Important Types of Syphilis of Joints.—Schlesinger several times found a syphilitic etiology in acute polyarthritis that had not been influenced by salicylates. Other affections of joints with or without fever may be due to syphilis or its combination with gonorrhea.

Low Blood Pressure.—Pal deals with conditions of abnormally low blood pressure. Extracts of pituitary, especially when combined with epinephrin, have a more permanent action than epinephrin alone.

Myeloid Reaction with Loss of Granulocytes from Blood.—Jagic and Spengler publish a case of hemorrhagic sepsis with progressive diminution of white corpuscles (to 800) and blood platelets. Among the white corpuscles the granulocytes were most affected (at last, 20 per cent. neutrophils, and absence of eosinophils throughout the disease). In spite of this, the necropsy revealed a strong myeloid reaction in the hemopoietic organs.

Mercury Diuresis.—Sternberg gives interesting historical facts on the use of preparations of mercury for diuresis. Paracelsus was the first to recommend it—very probably in the form of calomel. Sternberg follows the use of it through the centuries. In central Europe it was forgotten in the nineteenth century, until rediscovered by Jendrassik. Its prolonged use against which even the alchemists warned, caused poisoning, sometimes fatal.

After-Action of Galvanic Currents.—Erben, in experiments on the vestibular apparatus, finds that application of a galvanic current is followed by a prolonged period of opposite action. This is due to polarization in the depth of the tissues. He recommends, therefore, treatment with the opposite electrode. To get a prolonged depressing influence from the anode, apply the cathode.

Chromosomal and Incretory Hormones.—Bauer believes that the endocrine glands act as a condensor and multiplier of certain anlages. The growth of the body is primarily due to hereditary conditions, yet it is influenced by pituitary, thyroid and other glands.

Münchener medizinische Wochenschrift, Munich

70: 385-414 (March 30) 1923

Contractility of Capillaries and Cells of Adventitia. F. Marchand.—p. 385.
*"Typical" Fractures of Radius. L. Böhler.—p. 387.
*Treatment of Rectal Prolapse in Children. P. Widowitz.—p. 390.
Monosymptomatic Melancholia. H. Schmitz.—p. 393.
*Ehrlich's Diazo Reaction. M. Weiss.—p. 393.
Carcinoma Developed in an Atheroma of the Ear. C. Häbler.—p. 395.
Thrombosis of Aorta and Both Iliac Arteries with Ischemic Atonic Lumbar Paraplegia. L. Huismans.—p. 396.
Irritation of a Quiet Tuberculosis of Joint by Arsphenamin in a Case of Indurated Erythema (Bazin). F. Wirz.—p. 397.
Chronic Infection of Small Pelvis. F. Reif.—p. 397.
Prevention and Treatment of Bronchial Asthma and Hay Fever with Highly Concentrated Solutions of Calcium Chlorid. Schliack.—p. 398.
Saving of Space in Roentgen Rooms. H. Koch.—p. 399.
"Birth Injuries of Brain." A. Dietrich.—p. 400.
Friedmann's Treatment of Tuberculosis. Final Committee Report.—p. 401.
Syringomyelia, Atrophy and Dystrophy of Muscles. Curschmann.—p. 401.
Results of Examinations of School Children in Hipoltstein. Weigl.—p. 403.

Functional Treatment of "Typical" Fractures of Radius by Movement.—Böhler immobilizes the fracture absolutely, but takes care to exercise as many joints as possible without pain.

Postural Treatment of Rectal Prolapse in Children.—Widowitz treats children with rectal prolapse by a permanent prone position after replacing the prolapse and applying dressings. The condition heals usually in two or three weeks. The younger the child, the more it likes the ventral position; it is more natural for infants than the usual supine position. The pelvis of infants is still of quadrupedal type.

Ehrlich's Diazo Reaction.—Weiss reviews the more recent literature, and his researches. The coloring substance of normal urine (urochrome) is identical with urochromogen, which is revealed by Ehrlich's diazo, and by the author's permanganate test. Increased quantity of the substance is alone pathologic, and gives a good index of the destruction of body proteins.

Wiener klinische Wochenschrift, Vienna

36: 231-248 (March 29) 1923

Present State of Experimental Research in Herpes and Encephalitis. E. Lauda.—p. 231.
*Alimentary Asthma. L. Hofbauer.—p. 235.
Arsphenamin Dermatitis. H. Kronberger.—p. 237.
*Test of Permeability of Tubes. J. Novak.—p. 238.
Basis of Ointments. A. Seidel.—p. 240.
Rokitansky's Nomination as Prosector. M. Zeisel.—p. 241.

Alimentary Asthma.—Hofbauer recommends humming exercises, which teach the patient abdominal breathing and act as a massage of the bowels thus preventing intestinal putrefaction, which may be the cause of the attacks. He does not give details of his *Summtherapie* but refers to former communications on the subject; he has advocated it for twelve years in treatment of asthma.

Test of Permeability of Tubes.—Novak reports three cases in which Rubin's test was followed by conception in women, who were sterile before. No operation for sterility should be performed without a previous test of the permeability of the tubes.

Zentralblatt für Chirurgie, Leipzig

50: 585-632 (April 14) 1923

*Leukocyte Content of Normal Urine. E. Pflaumer.—p. 585.
*Resection of Pyloric Antrum in Gastric Ulcer. G. Kelling.—p. 588.
Echinococcus Cyst of the Spleen. E. Hennig.—p. 592.
Spastic Ileus on Hysterical Basis. K. Wohlgemuth.—p. 594.
Bandaging After Hare-Lip Operations. G. Ranft.—p. 598.

Leukocyte Content of Normal Urine.—Pflaumer's researches lead him to conclude that normal urine contains no leukocytes; urine containing leukocytes is always pathologic.

Resection of Pyloric Antrum in Gastric Ulcer.—Kelling expresses as follows his attitude toward gastric ulcer on the basis of many years' experience: It is quite improbable that a peptic ulcer originates without the presence of hydrochloric acid. The secretion of free hydrochloric acid will, in some cases, persist after resection of the pyloric antrum; this is especially true in ulcers near the pylorus. In these cases, it is advisable to resect large portions of the stomach, if secretion of hydrochloric acid is to be reduced. It has not been proved that the exclusion of the pyloric part has an unfavorable effect, provided products of digestion are not allowed to enter it, which of course presupposes a suitable technical procedure.

Zentralblatt für Gynäkologie, Leipzig

47: 625-656 (April 21) 1923

Median Suspension of Displaced Uterus. O. Polano.—p. 625.
*Protection of Ovaries During Irradiation. Offermann.—p. 631.
*Irradiation for Uterine Carcinoma. Zacherl and Lundwall.—p. 633.
Ileus in Pregnancy. S. Goldschmidt.—p. 636.
Drainage of Uterus without Drain Tube or Tampon in Infected Cases of Cesarean Section. A. v. Reding.—p. 640.

Protection of Ovaries During Postoperative Irradiation.—Offermann recalls that during postoperative irradiation after removal of a cancer of the uterus, the operator is inclined to overlook the fact that, unless some provision is made, the functions of the ovaries will likely be destroyed. After vaginal or abdominal removal of the uterus with a malignant tumor, Offermann recommends, in the transplantation technic, the method of Unterberger, who cuts the ovary into disks from 1 to 2 mm. thick and inserts them singly at various points between the rectus muscle and its anterior sheath. In order to leave a wide area free for irradiation, it is well to choose a place just above the umbilicus. Thus the ovaries are safely removed from the effects of the roentgen rays and can be protected by lead plates. While the proposed procedure will not guarantee ovarian function for a long period, it will maintain ovarian function in a measure for from three to five years, or until the body can learn to adapt itself to loss of this function. However, for three or four months after the operation, mild deficiency symptoms will appear, until the transplanted ovary has become established in its new environment. Some operators may prefer to transplant one ovary and leave the other in situ.

Prophylactic Roentgen Irradiation in Carcinoma of the Cervix Uteri.—Zacherl and Lundwall cite Gauss, Heimann, Warnekros and others whose reports show that postoperative irradiation has reduced very materially the percentage of recurrences. On the other hand, Perthes observed an increase of recurrences of from 61.5 to 69.5 per cent. after prophylactic irradiation; Tichy from 11.2 to 45.5 per cent.; and Kaestner from 33 to 47.6 per cent. To be sure, these figures and statements of bad results from prophylactic irradiation refer to carcinoma of the breast; cancer of the female reproductive organs seems to be more easily influenced by roentgen irradiation. The suggestion has been made that possibly the failures were due to too heavy dosage, especially since the Kiel clinic—using only two thirds of the erythema dose—has reported 77 per cent. of patients free from recurrence for a period of three years. Zacherl and Lundwall relate that, with from six to two yearly irradiations, 49.28 per cent. of their sixty-nine patients have been without recurrence for five years or more. At first the patients return for the irradiation every two months but the intervals are gradually lengthened to six months.